



OMVOH (Mirikizumab) PRESCRIBER ORDER FORM			
FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128			
□ NEW PATIENT OR			1.01
	Drug Change D	Oose Change Into	erval Change
Patient Name:	Pnone:		Date of Birth:
Address:			
All			
Allergies:			
Height:   inches   cm  Weight:   bs   kg  CLINICAL INFORMATION			
Primary Diagnosis Description:	CLINICAL INF	ORIVIATION	ICD-10 Code:
			Teb 10 code.
Is this the first dose?			
□ No – date of next dose due:			
Treatments – Tried and Failed:			
□ PPD (negative) – date:			
TB Status:   Last chest X-ray – date:	-		
□ Past positive TB infection, course taken:			
OMVOH PRESCRIPTION OMVOH (MIRIKIZUMAB) refill as directed x 1 year.			
Induction Dose:   ☐ Infuse 300mg IV over at least 30 minutes on Weeks 0, 4, and 8.  Confirm baseline LFTs and Bilirubin prior to administration and every 6 months thereafter.  Maintenance Dose: ☐ Give 200mg SC (given as 2 consecutive injections) at week 12, and every 4 weeks after.  Review LFTs and bilirubin every 6 months.			
ANCILLARY ORDERS			
Pre - Medication Orders  □ Acetaminophen 650mg PO 30 min before infusion.			
□ Diphenhydramine 25mg PO 30 min before infusion.			
☐ Methylprednisolone Succinate 125mg IV push 20 minutes prior to infusion.			
□ Other:			
PRN Hypersensitivity Meds:			
Epinephrine 0.3mg			
Solu-Cortef 100mg			
Solu-Medrol 125mg			
Diphenhydramine 25-50mg			
NS 500 ML (>30kg)			
I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.			
Prescriber Signature:	DDECCOURED I		Date:
Drossvihov Namo	PRESCRIBER II	NFORWATION	Fave
Prescriber Name: Address:	Phone:		Fax:
City, State:	Zip:		Office Contact:
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