

OMVOH (MIRIKIZUMAB) PRESCRIBER ORDER FORM		
FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128		
<input type="checkbox"/> NEW PATIENT OR <input type="checkbox"/> CHANGE ORDER: <input type="radio"/> Drug Change <input type="radio"/> Dose Change <input type="radio"/> Interval Change		
Patient Name:		Date of Birth:
Phone:		Gender:
Address:		
Allergies:		
Height:	<input type="checkbox"/> in <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg
CLINICAL INFORMATION		
Primary Diagnosis Description:		ICD-10 Code:
Is this the first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No – date of next dose due: _____		
Treatments – Tried and Failed:		
TB Status: <input type="checkbox"/> PPD (negative) – date: _____ <input type="checkbox"/> Active TB <input type="checkbox"/> Last chest X-ray – date: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Past positive TB infection, course taken: _____		
PRESCRIPTION		
OMVOH (MIRIKIZUMAB) refill as directed x 1 year. Induction Dose: <input type="checkbox"/> 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: <input type="checkbox"/> 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 <input type="checkbox"/> Acetaminophen 650mg PO 30 minutes before infusion. <input type="checkbox"/> Diphenhydramine 25mg PO/IV 30 minutes before infusion. <input type="checkbox"/> Methylprednisolone Succinate 125 mg IV push 20 minutes before infusion. <input type="checkbox"/> Other: _____		
PRN Hypersensitivity Meds: <ul style="list-style-type: none"> Epinephrine 0.3mg Solu-Cortef 100mg Solu-Medrol 125mg Diphenhydramine 25-50mg NS 500 ML (>30kg) 		
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>		
Prescriber Signature:		Date:
PRESCRIBER INFORMATION		
Prescriber Name:	Phone:	Fax:
Address:		NPI:
City, State, Zip:		Office Contact:
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