

**OMVOH**

**(mirikizumab)**

**PATIENT DEMOGRAPHICS**

|                                                                            |                         |
|----------------------------------------------------------------------------|-------------------------|
| Patient Name:                                                              | Patient's Phone Number: |
| Date of Birth:                                                             | Address:                |
| Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/> | City, State, Zip:       |
| Weight: _____ lbs or _____ kg                                              | Patient's Email:        |

**REQUIRED DOCUMENTATION**

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Tried/Failed Therapies
- Negative TB Results
- Baseline liver function tests (if available)
- Medication List

**PRIMARY DIAGNOSIS**

- |                                                                                             |                                                                                        |                                                                                             |
|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <input type="checkbox"/> K51 Ulcerative colitis                                             | <input type="checkbox"/> K51.8 Other ulcerative colitis                                | <input type="checkbox"/> K50.1 Crohns disease of large intestine                            |
| <input type="checkbox"/> K51.0 Ulcerative (chronic) pancolitis                              | <input type="checkbox"/> K51.819 Other ulcerative colitis w/ unspecified complications | <input type="checkbox"/> K50.111 Crohns disease of large intestine w/ rectal bleeding       |
| <input type="checkbox"/> K51.00 Ulcerative (chronic) pancolitis without complications       | <input type="checkbox"/> K51.9 Ulcerative colitis, unspecified                         | <input type="checkbox"/> K50.8 Crohns disease of both small and large intestine             |
| <input type="checkbox"/> K51.3 Ulcerative (chronic) rectosigmoiditis                        | <input type="checkbox"/> K50 Crohns disease                                            | <input type="checkbox"/> K50.813 Crohns disease of both small and large intestine w/fistula |
| <input type="checkbox"/> K51.311 Ulcerative (chronic) rectosigmoiditis with rectal bleeding | <input type="checkbox"/> K50.0 Crohns disease of small intestine                       | <input type="checkbox"/> K50.9 Crohns disease, unspecified                                  |
| <input type="checkbox"/> K51.5 Left sided colitis                                           | <input type="checkbox"/> K50.00 Crohns disease of small intestine w/o complications    |                                                                                             |
| <input type="checkbox"/> K51.518 Left sided colitis w/ other complication                   |                                                                                        |                                                                                             |

**PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)**

- |                                                   |                                          |                                             |                                                |
|---------------------------------------------------|------------------------------------------|---------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Diphenhydramine 25mg PO  | <input type="checkbox"/> Pepcid 20mg PO  | <input type="checkbox"/> Certrazine 10mg PO | <input type="checkbox"/> Solu-medrol 40mg IVP  |
| <input type="checkbox"/> Diphenhydramine 50mg PO  | <input type="checkbox"/> Pepcid 20mg IVP | <input type="checkbox"/> Tylenol 650mg PO   | <input type="checkbox"/> Solu-Cortef 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg IVP |                                          |                                             | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Diphenhydramine 50mg IVP |                                          |                                             |                                                |

**PRIMARY MEDICATION ORDER**

**Ulcerative Colitis**

- ☐ Induction Dosage: Week 0, Week 4, and Week 8: Infuse 300 mg intravenously over at least 30 minutes
- ☐ Maintenance Dosage: Week 12 and every 4 weeks thereafter: Inject 200 mg subcutaneously (given as two consecutive injections of 100 mg each)

**Crohn's Disease:**

- ☐ Induction Dosage: Week 0, Week 4, and Week 8: Infuse 900 mg intravenously over at least 90 minutes
- ☐ Maintenance Dosage: Week 12 and every 4 weeks thereafter: Inject 300 mg subcutaneously (given as two consecutive injections of 100 mg and 200 mg in any order)
- First Dose: ☐ Y ☐ N ☒ Refill X12 months unless otherwise noted: \_\_\_\_\_

**LINE USE/CARE ORDERS**

- ☒ Start PIV/ACCESS CVC ☒ Flush device per Suite Life Health's protocol (See [suitelifehealth.com](http://suitelifehealth.com) for detailed policy)
- ☐ Other Flush Orders: Please fax other line care orders if checking this box

**ADVERSE REACTION & ANAPHYLAXIS ORDERS**

- ☒ Administer acute infusion reaction and anaphylaxis medications per Suite Life Health's protocol (See [suitelifehealth.com](http://suitelifehealth.com) for detailed policy)
- ☐ Other: Please fax other reaction orders if checking this box

**PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION**

|                   |                                 |
|-------------------|---------------------------------|
| Provider Name:    | Office Contact:                 |
| Address:          | Phone:                          |
| City, State, Zip: | <input type="checkbox"/> Fax:   |
| NPI AND License:  | <input type="checkbox"/> Email: |

Provider Signature

Date

