



OMVOH
(mirikizumab-mrkz)

PATIENT INFORMATION

PATIENT NAME: PHONE #: ADDRESS: CITY, STATE, ZIP: DATE OF BIRTH: EMAIL: ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

- 1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List 6. Tried/Failed Therapies 7. Negative TB Results 8. Baseline liver function tests (if available)

PRIMARY DIAGNOSIS

K51.00 Ulcerative (chronic) pancolitis without complications K51.90 Ulcerative colitis, unspecified without complications Other

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic:

PRE-MEDICATIONS

Per infusion clinic protocol: No recommended standard pre-meds for Omvoh Provider Prescribed:

PRIMARY MEDICATION ORDER

Induction Doses (to be administered in infusion clinic): Maintenance Doses (to be self-administered by patient): Omvoh 300mg IV at weeks 0, 4, and 8. Infusion clinic will coordinate initial maintenance dose from Specialty Pharmacy: Omvoh 200mg SubQ... FIRST DOSE?: Yes No Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy) Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy) Other: (Please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: PHONE: OFFICE CONTACT: FAX: ADDRESS: EMAIL: CITY, STATE, ZIP: NPI AND LICENSE:

PROVIDER SIGNATURE DATE