

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

# Omvo<sup>TM</sup> (mirikizumab-mrkz) Standard Plan of Treatment for Gastroenterology

## PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

## DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

K51.0 - Universal Ulcerative (chronic) Pancolitis	K51.8 - Other Ulcerative (chronic) Colitis
K51.5 - Left sided Ulcerative (chronic) Colitis	K51.9 - Ulcerative Colitis, unspecified without complications
- Other:	

## REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5	<b>REQUIRED:</b> TB screening for new start	THERAPY:	<b>Continue current order until insurance approved</b>
6	Baseline LFTs and bilirubin level		

## MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive mirikizumab-mrkz if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset of deterioration neurological changes, and/or surgery.

### PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

<b>IV</b>	Diphenhydramine	25mg	50mg		<b>PO</b>	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

## MEDICATION/DOSE:

Omvo<sup>TM</sup> (mirikizumab-mrkz) 300mg/15ml in 50ml-250ml of NS given IV over at least 30 minutes. Flush entire line with NS at the end of the infusion.

**FREQUENCY:**

Week 0, week 4, and week 8

Other: \_\_\_\_\_

## SPECIAL/OTHER LAB ORDERS:

\_\_\_\_\_

\_\_\_\_\_

## NURSING ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Start PIV/Access CVC

Flush device per facility standard flushing procedure

Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.



## PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

## PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

_____	_____	_____
Dispense as written/Brand medically necessary	Substitution permitted	



## Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- Patient demographics - address, phone number, SS#, etc.**
- Insurance information - copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)