Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

| AMBULATORY INFUSION AND IN HOME/SPECIALTY ORDERS | | | | | |
|---|---|---|---|---|---|
| Referral Status: | | | | MRN: | |
| | New referral | | Order change | | Order Renewal |
| Patient preferred clinic: | | | | | |

Rev. 4.28.25

# Omvoh® (mirikizumab-mrkz) Standard Plan of Treatment for Crohn's Disease

## PATIENT DEMOGRAPHICS:

| | | | | | | |
|---|---|---|---|---|---|---|
| Patient Name: | | | | | | |
| Patient's Phone: | | Address: | | | | |
| Date of Birth: | | City, State, Zip: | | | | |
| Height in inches: | Weight: LB or KG | Gender: | Allergies: | | See list | NKDA |

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

| | | | |
|---|---|---|---|
| | K50.5___-Crohn's Disease (small intestine) | | K50.1___-Crohn's Disease (large intestine) |
| | K50.8___-Crohn's Disease (small and large intestine) | | K50.9___-Crohn's Disease |
| | _______- Other:___________________________ | | |

## REQUESTED DOCUMENTATION:

| | |
|---|---|
| 1 | Insurance information |
| 2 | Most recent History & Physical |
| 3 | Full medication list |
| 4 | Tried and failed therapies |
| 5 | **REQUIRED:** TB screening for new start |
| 6 | Baseline LFTs and bilirubin level |

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

| IF NO: | IF YES: |
|---|---|
| PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY: | LAST INFUSION DATE: |
| | NEXT INFUSION DATE: |

**IF ORDER CHANGE:**

| | |
|---|---|
| | **Continue current order until insurance approved** |

## AMBULATORY INFUSION 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 or deterioration neurological changes, and/or surgery.

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

| IV | | | | | | |
|---|---|---|---|---|---|---|
| Diphenhydramine | | 25mg | | 50mg | | |
| Methylprednisolone | | 40mg | | 125mg | | Other: |
| Famotidine | | 20mg | | 40 mg | | |
| Other: | | | | | | |

| PO | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Acetaminophen | | 325mg | | 500mg | | 650mg | | 1000mg |
| Famotidine | | 20mg | | 40mg | | | | |
| Diphenhydramine | | 25mg | | 50mg | | | | |
| Fexofenadine | | 60mg | | 180mg | | | | |
| Cetirizine | | 10mg | | | | | | |
| Loratadine | | 10mg | | | | | | |
| Other: | | | | | | | | |

### INDUCTION DOSE AND FREQUENCY:

☐ Omvoh® (mirikizumab-mrkz) 900mg in 250ml NS given IV over at least 90 minutes at week 0, week 4, and week 8.

**Flush entire line with 20ml NS at the end of the infusion.**

### SPECIAL/OTHER LAB ORDERS:

☐ ________________________________________

________________________________________

## IN HOME/SPECIALTY PHARMACY ORDERS:

### SUBCUTANEOUS DOSE/ FREQUENCY:

☐ Omvoh® (mirikizumab-mrkz) 300 mg given subcutaneously at week 12 and every 4 weeks thereafter

**Some commercial insurance plans require maintenance doses to be provided by the plan's specialty pharmacy. Providers will be notified if Palmetto Infusion cannot dispense the maintenance doses due to plan restrictions or patient preference.**

☐ Other: ________________________________

Refills x 12 months unless noted otherwise here:

## NURSING 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
- ☑ In Home Supply orders: All supplies for drug administration and ADR kit to be provided for in home use.

## ADVERSE REACTION ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website. Home standing orders including Anaphylaxis Kit dispense as written and administer for mild and severe reactions are provided.

## 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 | |