

AMBULATORY INFUSION AND IN HOME/SPECIALTY ORDERS

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

OmvoH® (mirikizumab-mrkz) Standard Plan of Treatment for Ulcerative Colitis Rev 4.28.25

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)

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	IF ORDER CHANGE: <input type="checkbox"/> Continue current order until insurance approved
5	REQUIRED: TB screening for new start	THERAPY:	
6	Baseline LFTs and bilirubin level		

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		PO	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:					

INDUCTION DOSE AND FREQUENCY:

OmvoH® (mirikizumab-mrkz) 300mg/15ml in 100ml NS given IV over at least 30 minutes at week 0, week 4, and week 8.

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

SPECIAL/OTHER LAB ORDERS:

IN HOME/SPECIALTY PHARMACY ORDERS:
MAINTENANCE DOSE AND FREQUENCY

OmvoH® (mirikizumab-mrkz) 200mg given subcutaneously at week 12 and 4 weeks thereafter.

Other: _____

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.

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