AMBULATORY INFUSION AND IN HOME/SPECIALTY ORDERS		
Referral Status:		MRN:
☐ New referral	☐ Order change	☐ 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:

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: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
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) 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.

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	

Palmetto INFUSION

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