NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-307-2244
Phone: 405-515-2470

ORD

Mirikizumab (Omvoh)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	**Office Phone Number:**	**Fax Number:**
Insurance:	**Group Number:**	**Policy Number:**
Hospitalization Status:	**Patient Weight (kg):**	**Height (inches):**
☑ Outpatient to Outpatient Infusion Center		
Allergies:		

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

Diagnosis Code/Description for treatment: _____

☐ Adult Crohn Disease (K50.00)
☐ Adult Ulcerative Colitis, unspecified (K51.90)
☐ Adult Ulcerative Colitis, other (K51.80)

Laboratory

☐ CBC WITH DIFFERENTIAL ☐ COMPREHENSIVE METABOLIC PANEL
Other: _____

Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port
☑ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

Infusion – Mirikizumab-mrkz (Omvoh) [J2267 : 1 MG = 1 unit]

Ulcerative Colitis

☐ Mirikizumab (Omvoh) 300 MG in 100 mL of 0.9% Normal Saline Solution INTRAVENOUS ONCE over 30 minutes.

Crohn's Disease

☐ Mirikizumab (Omvoh) 900 MG diluted in 0.9% Normal Saline Solution to a final volume of 250 mL INTRAVENOUS ONCE over 90 minutes.

Date of Service: First Dose (_____) next initial dose 4 weeks after first initial dose, then 3rd dose is 8 weeks after first initial dose. If patient tolerates doses, may begin self-administering maintenance dosing at week 12.

Infusion Reaction

☑ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

☑ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE

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DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES