

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):
<input checked="" type="checkbox"/> 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-mrz (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: _____
11242512

TIME: _____

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PHYSICIAN'S SIGNATURE

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