Provider Order Form

OMVOH (MIRIKIZUMAB-MRKZ)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Ulcerative Colitis K51. _____ ☐ Other _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Omvoh (Mirikizumab-Mrkz), IV Mix in 50ml to 250ml 0.9% sodium chloride	☐ 300 mg/15 ml	☐ Infuse at week 0, 4, and 8.
☐ Omvoh (Mirikizumab-Mrkz), Subcutaneous Injection	☐ 200 mg	☐ 200 mg (given as two consecutive injections of 100 mg each) at Week 12, and every 4 weeks thereafter.
☐ Omvoh (Mirikizumab-Mrkz), Subcutaneous Injection	☐ 200 mg	☐ Maintenance: every 4 weeks

Refills ☐ Zero ☐ 12 months ☐ ___ Order valid for 1 year unless otherwise stated.
☒ Infuse over at least 30 minutes.
☒ Flush with 0.9% sodium chloride at infusion completion.
☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ Other _____ ☐ at each dose ☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ TB status results ☐ Liver Enzymes and Bilirubin levels

Provider Signature Date