



# OmvoH Order Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

### DIAGNOSIS:

- Ulcerative Colitis ICD-10: \_\_\_\_\_
- Crohn's Disease ICD-10: \_\_\_\_\_
- Other: \_\_\_\_\_ ICD-10: \_\_\_\_\_

### ORDER FOR OMVOH (MIRIKIZUMAB-MRKZ):

#### IV Induction Dose:

- 300mg IV at week 0, 4, and 8 (for UC)
- 900mg IV at week 0, 4, and 8 (for Crohn's)

### PRE-MEDICATIONS:

- Pre-Medications (if necessary): \_\_\_\_\_

### MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- Nevada Infusion Hypersensitivity Reaction Order Set
- Other: \_\_\_\_\_

ACCESS: Peripheral IV, Port, Midline, or PICC line

FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml

NURSING: Per Nevada Infusion

LABS ORDERS: \_\_\_\_\_ Fax results to: \_\_\_\_\_

### Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- Signed provider orders (page 1)

### PROVIDER INFORMATION:

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Point of Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478**

\*\*Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. \*\*



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

- Patient demographic and insurance information
- Patient's current medication list
- Supporting recent clinical notes and H&P (to support primary diagnosis)
- Supporting documentation to include past tried and/or failed therapies
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy:
  - Does the patient have a contraindication/intolerance or failed trial to corticosteroids or immunomodulators (i.e., 6-MP, azathioprine, budesonide)?
    - Yes OR  No
    - If yes, which drug(s)? \_\_\_\_\_
  - Does the patient have a contraindication/intolerance or failed trial to any biologic (i.e., Humira, Remicade, Stelara, Cimzia)?
    - Yes OR  No
    - If yes, which drug(s)? \_\_\_\_\_
- Include labs and/or test results to support diagnosis
- If applicable - Last known biological therapy: \_\_\_\_\_ and last date received: \_\_\_\_\_. If patient is switching to biologic therapies, please perform a wash-out period of \_\_\_\_\_ weeks prior to starting Omvoh.

**Additional REQUIRED Information:**

- TB screening test completed - please include results
  - Positive OR  Negative
- Baseline liver function tests and bilirubin - please include results
- Other medical necessity: \_\_\_\_\_

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