Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

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:

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

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: _____

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. **

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Patient Name: _____ DOB:_____

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

☐ Signed provider orders (page 1)

☐ 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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