INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Omvoh *mirikizumab-mrkz*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Moderate to severe active ulcerative colitis, ICD 10: K51.
☐ Moderate to severe active Crohn's disease, ICD 10: K50.
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB test ☐ Demographics ☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DIAGNOSIS	DOSE / FREQUENCY	ROUTE
Omvoh	☐ Ulcerative Colitis	Initial: 300 mg at weeks 0, 4, & 8; then maintenance: 200 mg at week 12 and every 4 weeks	☐ IV ☐ SubQ
	☐ Crohn's	Initial: 900 mg at weeks 0, 4, & 8; then maintenance: 300 mg at week 12 and every 4 weeks	☐ IV ☐ SubQ

x3 IV infusions need to be completed prior to SubQ injections.
☐ Check this box if you do NOT want Infuse Care to complete the insurance portion for SubQ.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____