Agile Infusion Services LLC
Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

OMVOH MEDICATION ORDER

This order is only for the infusion version of Omvoh, not the injectable version.

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds* _____

■ **Diagnosis** *Please provide the diagnosis and ICD-10 code to the highest possible coding level.*

☐ K51.0__ Ulcerat. (chron) pancolitis _____
☐ K51.2__ Ulcerative (chron) proctitis _____
☐ K51.3__ Ulcerative (chron) rectosig. _____
☐ K51.4__ Inflammatory polys of colon _____
☐ K51.5__ Left sided colitis _____
☐ K51.8__ Other ulcerative colitis _____
☐ K51.9__ Ulcerative colitis, unspec, _____
☐ K52.1 Toxic gastroenteritis and colitis

■ **Details Needed for Approval**

- Provide evidence of no latent TB within 3 months or, if positive, document start of anti-TB therapy.
- Circle the severity of the patient's Ulcerative Colitis (UC)? *mild* *moderate-to-severely active* *severely active*
- Has the patient had prior or concurrent inadequate response to oral corticosteroids and/or immunosuppressants? _____ *If yes, please provide detailed notes, including duration and nature of inadequate response, for all such meds.*
- Does the patient have a history of failure, contraindication or intolerance to targeted immunomodulators FDA-approved for the treatment of UC? _____ *If yes, please provide detailed notes, including duration, in chart notes, on all such meds.*
- Is the patient planning to concurrently receive another targeted immunomodulator, such as Enbrel or Xeljanz? _____ *If yes, please provide details on the medication, dosage, and condition which is being treated by that other medication.*
- If there is any reason the patient cannot self-administer, provide detailed documentation in chart notes.

■ **Omvoh IV (mirikizumab) Medication Order**

☐ 3 induction doses of 300mg via IV at weeks 0, 4 and 8

Administer according to manufacturer's instructions. Post infusion flush line. Check vitals and monitor for signs and symptoms of an infusion reaction at start, throughout infusion, and after completion.

■ **Rescue Management in case of Infusion Therapy Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including Diphenhydramine, Methylprednisolone, Albuterol and oxygen as needed. Famotidine 20mg IVP for minor cutaneous reactions which do not respond to diphenhydramine.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Ordering Provider Authorization**

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.