INTRAMED Plus
infusion services

OMVOH™

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis:

_____ Crohn's Disease — ICD-10 Code: K50._____

_____ Ulcerative Colitis — ICD-10 Code: K51._____

_____ Other: _____ — ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:
  - o TB results, Liver enzymes, and Bilirubin levels
- Medication List
- Previous Drug Therapy History, including therapies trialed/failed and date of last administration:
  - ❑ **Entyvio** ❑ **Humira** ❑ **inflixmab** ❑ **Simponi** ❑ **Stelara** ❑ **Other:** _____
  - o Date: _____ Desired Washout Period: _____ week(s)

Patient
Weight: _____ lbs.
Height _____ in.

OMVOH™ (mirikizumab-mrkz) J Code: J2267

4. Drug Order:

Induction Dosing

❑ (UC Diagnosis) Administer 300 mg IV over at least 30 minutes at weeks 0, 4, and 8. Doses Authorized: 3 (three)

❑ (CD Diagnosis) Administer 900 mg IV over at least 90 minutes at weeks 0, 4, and 8. Doses Authorized: 3 (three)

Maintenance Dosing

*Maintenance Regimen: To begin 4 weeks after last IV induction dose (week 12) and every 4 weeks thereafter

❑ (UC Diagnosis) Inject 200 mg subcutaneously (given as two injections of 100 mg each) every 4 weeks.

Doses Authorized: 12

❑ (CD Diagnosis) Inject 300 mg subcutaneously (given as two injections of 100 mg and 200 mg in any order) every 4 weeks.

Doses Authorized: 12

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written — Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**