

Mirikizumab (OmvoTM) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code(s): _____

Is this the first dose? Yes - Date of first dose: _____ No - Date of next dose: _____

TB Status PPD (negative) – date: _____ Active TB Unknown
 Last chest x-ray – date: _____ Other _____
 Past positive TB infection, course taken: _____

Mirikizumab (OmvoTM) Prescription

Mirikizumab (OmvoTM) refill as directed x 1 year

- Initial Dose: Infuse 300 mg IV over at least 30 minutes at Weeks 0, 4, and 8.
- Maintenance Dose: Infuse 200mg subcutaneously at week 12 and every 4 weeks thereafter.
- Other: _____

After each infusion, the IV tubing will be flushed with NS 30ml using a 50ml bag.

Ancillary Orders

Anaphylaxis Orders

- Treat per Froedtert Home and Specialty Infusion protocol.

Medication Orders

- Other: _____

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

- Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.
- Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

Lab Orders

- No labs ordered at this time.
- Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
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