CURBSIDE
INFUSION SERVICES

Omvoh® (Mirikizumab) Order Form

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **ICD-10 Diagnosis:** _____

Medication Order:

Ulcerative Colitis Induction dosing:

☐ Mirikizumab 300 mg IV over 30 minutes at weeks 0, 4, and 8

(Followed by home subcutaneous maintenance dosing at week 12 and every 4 weeks thereafter.)

Crohn's Disease Induction dosing:

☐ Mirikizumab 900 mg IV over 90 minutes at weeks 0, 4, and 8

(Followed by home subcutaneous maintenance dosing at week 12 and every 4 weeks thereafter.)

Monitoring:

Last date and type of TB test: _____(please fax copy of results with order)

Last date of LFT panel: _____(please fax copy of results with order)

☐ Draw LFTs at baseline.

Other Comments: _____

Prescriber Printed Name:_____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____