Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Omvoh® (mirikizumab-mrkz) Infusion Order (11/4/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ K50.1___ - Crohn's disease (large intestine)	☐ K50.5___ - Crohn's disease (small intestine)
☐ K50.8___ - Crohn's disease (small and large intestine)	☐ K50.9___ - Crohn's disease, unspecified
☐ K51.0___ - Universal ulcerative (chronic) pancolitis	☐ K51.5___ - Left side ulcerative (chronic) colitis
☐ K51.8___ - Other ulcerative (chronic) colitis	☐ K51.9___ - Ulcerative colitis, unspecified without complications
☐ Other:	

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion:
Complete Medication List - Include all tried and failed meds	Next infusion due date:
	If this is an order change only, indicate if the current therapy should be administered until insurance
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

☑ Hold treatment and notify provider IF: - Temperature is GREATER THAN 100oF; - Patient complains of symptoms of acute viral or bacterial infection; -Patient is taking an antibiotic for current infection

☑ Required Lab Results: Hepatic Function Panel and Quantiferon Gold PRIOR to FIRST treatment (**Fax labs with order**)

☑ Notify Provider IF: Quantiferon Gold: POSITIVE or not on file; - Hepatic Function Panel: ABNORMAL or not on file

Provider Communication:

☑ To Do Now: Order prescription OUTSIDE of the therapy plan for Omvoh (mirikizumab) SC Pen and send to Market Specific Specialty Pharmacy

Nursing Communication:

☑ Start PIV/Access CVC and flush device per Atrium Health Protocol.

☑ Obtain vital signs PRE-treatment and POST-treatment. Obtain vital signs PRN during treatment.

☑ Monitor patient for signs of reaction for 30mins after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 650mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg IV ONCE

☐ Hydrocortisone sodium succinate (Solu-Cortef) 100mg IV ONCE

☐ Loratadine (Claritin) 10mg PO ONCE

☐ Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy:

☐ Mirikizumab-mrkz (Omvoh) for Ulcerative Colitis

- ☐ 300mg IV administered over 30 minutes Week 0, Week 4, and Week 8

☐ Mirikizumab-mrkz (Omvoh) for Crohn's Disease

- ☐ 900mg IV administered over 90 minutes Week 0, Week 4, and Week 8

Supportive Care Medications:

☑ Sodium chloride 0.9% bolus 500mL ONCE PRN for dehydration.

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). ONLY administer if not given as a pre-medication.

☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: