Hy-Vee health INFUSION CARE

OMVOH™ IV
Provider Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Address: _____ **City/ST/Zip:** _____

Allergies: _____ ☐ NKDA **Weight:** _____ ☐ lbs ☐ kg **Height:** _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

Diagnosis*

***ICD 10 Code Required** ☐ Ulcerative colitis (K51.00-K51.919), ICD10 _____

Infusion Orders

MEDICATION	DOSE	DIRECTIONS/DURATION
Omvoh™ (mirikizumab)	300 mg	Infuse IV over 30 minutes every 4 weeks x 3 doses

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ **Date of next treatment:** _____

PREMEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650 mg PO ☐ Diphenhydramine 25 mg PO

☐ Methylprednisolone 40 mg IVP -OR- ☐ Hydrocortisone 100 mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Reffering Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

Required Clinical Documentation

Please attach medical records: Initial H&P, current MD progress notes, medication list and labs/test results to support diagnosis.

LAB & TEST RESULTS REQUIRED PRIOR TO TREATMENT (ATTACH RESULTS):

☐ LFTs ☐ Bilirubin ☐ TB Test

o TB screening (submit results from within 12 months to start therapy and annually to continue therapy)

o Annual TB screening to be done by: ☐ Infusion Center ☐ Referring Physician

MEMBER TRIED & FAILED AFTER A 90 DAY TRAIL PERIOD, HAS A CONTRAINDICATION OR INTOLERANCE TO THE FOLLOWING BIOLOGICS: ONE of the following adalimumab products: Humira, Cyltezo, Hyrimoz or Stelara SQ

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

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Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX ☐ Phoenix, AZ ☐ Other _____

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