ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN				
Allergies/Reactions:	Fax all infusions to: 833-380-8800 Please mark the appropriate infusion center:	□ Auburn □ Gig Har	ore Infusion Center Infusion Center bor Infusion Services p Infusion Center	☐ DHEC Infusion Center☐ North Spokane Infusion Center☐ North Star Lodge Infusion Center☐ Description
ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.				
Mirikizumab-mrkz (Omvoh):				
Deticat Names				
Patient Name:Requested Date of Service://				
ICD -10 Code:				
<b>Diagnosis:</b> ☐ Ulcerative Colitis	<u>ICD -10 Code</u> .			
Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation **If required documentation not received with order, scheduling of treatment will be delayed until complete information is available**				
Baseline Labs Required:  • Latent TB testing	Data	,	Dogultor	
<ul> <li>CMP (liver enzyme and bilirubin levels)</li> </ul>				
Maintenance Labs Required:  CMP prior to infusions				
☑ <b>IV Access:</b> Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.				
Treatment Regimen:  Mirikizumab-mrkz (Omvoh)  300 mg IV over 30 minutes at weeks 0. 4, and 8; followed by  200 mg SUBQ (given as two consecutive injections of 100 mg each) at week 12, and every 4 weeks thereafter				
✓ Vital signs: Check vital signs prior to and at completion of infusion. Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)				
If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.)  • Consult MultiCare hypersensitivity guideline for treatment management  • Notify provider of reaction, assessment and need for further orders				
Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.				
Was consent obtained: ☐ Yes ☐ No (if yes, please send DOCUMENTATION of consent with order)				
<u></u>			· <del></del>	
Provider Signature	Print Name		Date	Time
Another brand of drug, identical in form and content, may be dispensed unless checked   Orders expires in 12 months**				

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
ULCERATIVE COLITIS

MultiCare 🕰

