Wells Infusion Centers

OMVOH ORDER FORM

PLEASE EMAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO REFERRALS@WELLSINFUSION.COM. YOU CAN ALSO FAX IT TO 1-570-9INFUSE (1-570-946-3873)

Preferred Location: _____

Patient Information

Patient Name: DOB: Sex: ☐ M ☐ F

Address: Phone: Email:

Height (in): Weight (lb): Referral Status: ☐ New ☐ Updated ☐ Renewal

Infusion/ Injection Information

Primary ICD-10 Code: Primary ICD-10 Description:

Other ICD-10 Codes: Other ICD-10 Descriptions:

Omvoh (mirikizumab-mrkz) Dosing Info:

- ☐ Crohn's: 900mg IV at week 0, 4, 8
- ☐ Ulcerative Colitis: 300mg IV at week 0, 4, 8

Required Documentation:

- ☐ Full Patient Chart
- ☐ Insurance Cards (Front and Back)
- ☐ Clinical Notes Supporting Diagnosis
- ☐ List of Current Medications, Conditions, and Allergies
- ☐ Liver Function Tests/ Bilirubin
- ☐ TB Results within 12 months

Premedications:

- ☐ Acetaminophen _____ mg ☐ PO ☐ IV
- ☐ Cetirizine _____ mg ☐ PO
- ☐ Diphenhydramine _____ mg ☐ PO ☐ IV
- ☐ Hydrocortisone _____ mg ☐ IV
- ☐ Loratadine _____ mg ☐ PO
- ☐ Methylprednisolone _____ mg ☐ IV
- ☐ Other: _____ _____ mg ☐ PO ☐ IV

Ordering Provider Information

Practice Name: Practice Phone: Practice Fax:

Practice Address: Referral Coordinator Name:

Referral Coordinator Email: Referral Coordinator Phone:

Ordering Provider: Provider NPI: Specialty:

All Injections, Infusions, and Rescue Management for Reactions will be handled in accordance with Wells Infusion's Protocols. Orders are valid for 1 year unless stated otherwise.

Provider Name _____ Provider Signature _____ Date _____

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CALL 570-4INFUSE (570-446-3873) OR EMAIL INFO@WELLSINFUSION.COM