Oregon Health & Science University Hospital and Clinics Provider's Orders

PO9031

ADULT AMBULATORY INFUSION ORDER

Mirikizumab-mrkz (OMVOH) Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
3. Patients should not have an active ongoing TB infection at the onset of mirikizumab therapy.
4. Hypersensitivity, including anaphylaxis, mucocutaneous erythema, and pruritus during the IV infusion, has been reported.
5. Live or live attenuated vaccines should not be given concurrently.
6. Mirikizumab subcutaneous injections are included on the Center for Medicare & Medicaid Services Self-Administration Drug Exclusion List. An outpatient prescription for subcutaneous maintenance dosing will need to be supplied by the provider for patients with traditional Medicare (Medicare A/Medicare B) for self-administration.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

- ☐ COMPLETE METABOLIC PANEL, Routine, ONCE

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold infusion and contact provider if patient has signs or symptoms of infection.
2. TREATMENT PARAMETER – Hold treatment and contact provider if TB test result is positive or if screening has not been performed.
3. TREATMENT PARAMETER – Hold treatment and contact provider for AST/ALT greater than 3 x ULN or ALK Phos greater than 2.5 X ULN.

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MEDICATIONS:

- ❑ **Ulcerative Colitis**
  - ❑ **Induction:** Mirikizumab-mrkz (OMVOH) 300 mg in sodium chloride 0.9 %, intravenous, ONCE, infuse over 30 minutes, at weeks 0, 4, and 8**.**
  - ❑ **Maintenance:** Mirikizumab-mrkz (OMVOH) 200 mg, subcutaneously, ONCE, every 4 weeks, starting at week 12

- ❑ **Crohn's Disease**
  - ❑ **Induction:** Mirikizumab-mrkz (OMVOH) 900 mg in sodium chloride 0.9 %, intravenous, ONCE, infuse over 30 minutes, at weeks 0, 4, and 8**.**
  - ❑ **Maintenance:** Mirikizumab-mrkz (OMVOH) 300 mg, subcutaneously, ONCE, every 4 weeks, starting at week 12

AS NEEDED MEDICATIONS:

1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for fever
2. diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

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Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

☑ **Please indicate the patient's preferred clinic location below**

☐	**HILLSBORO MEDICAL CENTER** 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
☐	**ADVENTIST HEALTH – PORTLAND** Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
☐	**ADVENTIST HEALTH – COLUMBIA GORGE** **Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058**	Phone **(541) 296-7585** Fax **(541) 296-7610**