OMVOH (mirikizumab-mrkz) Referral Form

www.biohealthic.com | info@biohealthic.com

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

- ☐ CBC at each dose every ____________________
- ☐ CMP at each dose every ____________________
- ☐ CRP at each dose every ____________________
- OTHER

PREMEDICATIONS

- ☐ acetaminophen (Tylenol) 500mg 650mg / 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg 50mg PO IV
- methylprednisolone (Solu-Medrol) 40mg 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: ____
- Dose: ____________________ Route: __________________
- Frequency: ____

OMVOH THERAPY ADMINISTRATION

300mg IV at week 0, 4, and 8

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Medication List and H&P

Liver Function Tests/Bilirubin

TB Results within 6 months

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Have a Question? (786)460-6044

Fax Referral Form To: (786)219-3917

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