

# Infusion Order Form

## Patient Information:

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**DOB**

\_\_\_\_\_  
**Phone Number**

## Medical Information:

Primary Diagnosis:

☐ Crohn's Disease

ICD-10 Code: K50.\_\_\_\_

☐ Ulcerative Colitis

ICD-10 Code: K51.\_\_\_\_

☐ Other \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_

Allergies: \_\_\_\_\_ (or attach list)

## Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Relevant labs and tests including:
  - TB Screening Results
  - Liver Enzymes
  - Bilirubin Levels
- Medication List
  - Include documentation of previously trialed and failed therapies with documentation of last administration, reason for discontinuation or contraindication(s) to alternative therapies

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

## Omvo<sup>h</sup> (mirikizumab-mrkz) Orders:

☐ Crohn's Disease:

Administer 900 mg intravenously over at least 90 minutes at Weeks 0, 4 and 8 for a total of 3 IV doses

☐ Ulcerative Colitis :

Administer 300 mg intravenously over at least 30 minutes at Weeks 0, 4 and 8 for a total of 3 IV doses

**Pre-Medication Orders:** \_\_\_\_\_

\*No pre-medications are recommended based on the manufacturer's PI

**Lab Orders:** ☐ Liver enzymes and bilirubin at baseline and every \_\_\_\_\_ weeks

☐ Other: \_\_\_\_\_

## Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

\_\_\_\_\_  
**Prescriber's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Prescriber's Printed Name**

\_\_\_\_\_  
**Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:



Revitalize



Revitalize Locations



InfusionPlus

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