

Ultomiris® Referral Form



Fax Completed Form To:

Phone:

| PATIENT INFORMATION | | | |
|-----------------------------|----------------|-----------------|-------------|
| Patient Name: | Date of Birth: | Referral Date: | |
| Address: | | City/State/Zip: | |
| Home Phone: | Cell Phone: | Work Phone: | |
| Secondary Contact: | Height: | Weight: | Male Female |
| Patient Diagnosis & ICD-10: | | | |
| Allergies: | | | |

| PROVIDER INFORMATION | | |
|--|--------|-----------------|
| Physician Name: | Lic.#: | DEA #: |
| Practice Name: | | NPI#: |
| Address: | | City/State/Zip: |
| Office Contact: | Phone: | Fax: |
| Supervisory Physician (if applicable): | | |

| PLEASE ATTACH | |
|---|---|
| Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) Line access documentation/verification if applicable | Vaccine status (any vaccination) and documentation of any recent vaccinations Clinical documentation on any recent meningococcal infections Documentation of a meningococcal vaccination Letter of medical necessity if drug dosing or indication is outside of FDA guidelines |

| NURSING & LAB ORDERS | |
|--|----------------------------------|
| Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. | |
| Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line | |
| Lab Orders: | Lab Date & Frequency: |

| PRESCRIPTION ORDERS | | | |
|---|---|--|---|
| Anaphylaxis Kit: (Check all that apply) | Epinephrine 0.3mg IM as needed Diphenhydramine _____ mg IV infusion as needed | Solu-cortef 250mg-500mg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed | Solu-Medrol 60mg - 125mg IV infusion as needed Other |
| Pre-Medications: (Check all that apply) | Acetaminophen _____ mg PO _____ minutes prior to infusion Diphenhydramine _____ mg PO ---OR--- IV infusion _____ minutes prior to infusion | Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion | Other |
| Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary | | | |

| PRODUCT | PRESCRIPTION INFORMATION | | | REFILLS | |
|--|--|--|--|---------|------|
| Is this a first dose? Yes No If No, when was last dose given? _____ When is patient due for next dose? _____ | | | | | |
| Is the prescriber enrolled in the Ultomiris REMS program? Yes No | | | | | |
| Ultomiris | Loading Dose | | | NONE | |
| PNH and aHUS | For patients 5-10kg administer 600mg IV infusion via gravity ---OR--- pump over at least 1.4 hours | | | | |
| | For patients 10-20kg administer 600mg IV infusion via gravity ---OR--- pump over at least 0.8 hours | | | | |
| | For patients 20-30kg administer 900mg IV infusion via gravity ---OR--- pump over at least 0.6 hours | | | | |
| | For patients 30-40kg administer 1,200mg IV infusion via gravity ---OR--- pump over at least 0.5 hours | | | | |
| PNH, aHUS and gMG | For patients 40-60kg administer 2,400mg IV infusion via gravity ---OR--- pump over at least 0.8 hours | | | | |
| | For patients 60-100kg administer 2,700mg IV infusion via gravity ---OR--- pump over at least 0.6 hours | | | | |
| | For patients >100kg administer 3,000mg IV infusion via gravity ---OR--- pump over at least 0.4 hours | | | | |
| PNH and aHUS | Maintenance Dose | | | _____ | |
| | For patients 5-10kg administer 300mg IV infusion via gravity ---OR--- pump over at least 0.8 hours every 4 weeks | | | | |
| | For patients 10-20kg administer 600mg IV infusion via gravity ---OR--- pump over at least 0.8 hours every 4 weeks | | | | |
| | For patients 20-30kg administer 2,100 IV infusion via gravity ---OR--- pump over at least 1.3 hours every 8 weeks | | | | |
| PNH, aHUS and gMG | For patients 30-40kg administer 2,700mg IV infusion via gravity ---OR--- pump over at least 1.1 hours every 8 weeks | | | | |
| | For patients 40-60kg administer 3,000mg IV infusion via gravity ---OR--- pump over at least 0.9 hours every 8 weeks | | | | |
| | For patients 60-100kg administer 3,300mg IV infusion via gravity ---OR--- pump over at least 0.7 hours every 8 weeks | | | | |
| For patients >100kg administer 3,600mg IV infusion via gravity ---OR--- pump over at least 0.5 hours every 8 weeks | | | | | |
| OTHER | | | | | NONE |

By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

| | | | | | |
|--|------------|------|---|------------|------|
| Prescriber's Signature Dispense as Written | Print Name | Date | Prescriber's Signature Substitution Permitted | Print Name | Date |
|--|------------|------|---|------------|------|



ACHC ACCREDITED

