Ultomiris® Referral Form

amerita
specialty infusion services

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 ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV infusion _____minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ 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 PNH and aHUS	**Loading Dose** ☐ 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	NONE
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 ☐ For patients 30-40kg administer 2,700mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 1.1 hours every 8 weeks	_____
PNH, aHUS and gMG	☐ 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 **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

AME_ULTOMIRIS REFER 6.24

ameritaiv.com

urac ACCREDITED Specialty Pharmacy Expires 08/01/2021 ACHC ACHC ACCREDITED PCAB ACCREDITED Compounding Pharmacy