

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:	<input type="checkbox"/> Male <input type="checkbox"/> 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	
<input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical)	<input type="checkbox"/> Vaccine status (any vaccination) and documentation of any recent vaccinations
<input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results	<input type="checkbox"/> Clinical documentation on any recent meningococcal infections
<input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates)	<input type="checkbox"/> Documentation of a meningococcal vaccination
<input type="checkbox"/> Line access documentation/verification if applicable	<input type="checkbox"/> 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 - <input type="checkbox"/> 10units/mL ---OR--- <input type="checkbox"/> 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line	
Lab Orders:	Lab Date & Frequency:

PRESCRIPTION ORDERS			
Anaphylaxis Kit:	<input type="checkbox"/> Epinephrine 0.3mg IM as needed	<input type="checkbox"/> Solu-cortef 250mg-500mg IV infusion as needed	<input type="checkbox"/> Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply)	<input type="checkbox"/> Diphenhydramine _____ mg IV infusion as needed	<input type="checkbox"/> NS Hydration 500 ml IV infusion over 30 minutes as needed	<input type="checkbox"/> Other
Pre-Medications:	<input type="checkbox"/> Acetaminophen _____ mg PO _____ minutes prior to infusion	<input type="checkbox"/> Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion	
(Check all that apply)	<input type="checkbox"/> Diphenhydramine _____ mg <input type="checkbox"/> PO ---OR--- <input type="checkbox"/> IV infusion _____ minutes prior to infusion	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, when was last dose given? _____ When is patient due for next dose? _____		
Is the prescriber enrolled in the Ultomiris REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Ultomiris	Loading Dose	NONE
PNH and aHUS	<input type="checkbox"/> For patients 5-10kg administer 600mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 1.4 hours	
	<input type="checkbox"/> For patients 10-20kg administer 600mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.8 hours	
PNH, aHUS and gMG	<input type="checkbox"/> For patients 20-30kg administer 900mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.6 hours	
	<input type="checkbox"/> For patients 30-40kg administer 1,200mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.5 hours	
PNH, aHUS and gMG	<input type="checkbox"/> For patients 40-60kg administer 2,400mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.8 hours	
	<input type="checkbox"/> For patients 60-100kg administer 2,700mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.6 hours	
	<input type="checkbox"/> For patients >100kg administer 3,000mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.4 hours	
	Maintenance Dose	
PNH and aHUS	<input type="checkbox"/> For patients 5-10kg administer 300mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.8 hours every 4 weeks	
	<input type="checkbox"/> For patients 10-20kg administer 600mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.8 hours every 4 weeks	
	<input type="checkbox"/> For patients 20-30kg administer 2,100 IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 1.3 hours every 8 weeks	
	<input type="checkbox"/> For patients 30-40kg administer 2,700mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 1.1 hours every 8 weeks	
PNH, aHUS and gMG	<input type="checkbox"/> For patients 40-60kg administer 3,000mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.9 hours every 8 weeks	
	<input type="checkbox"/> For patients 60-100kg administer 3,300mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.7 hours every 8 weeks	
	<input type="checkbox"/> For patients >100kg administer 3,600mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 0.5 hours every 8 weeks	
<input type="checkbox"/> 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 _____

