

# 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	
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.	
<b>Flush Orders:</b> 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	
<b>Lab Orders:</b>	<b>Lab Date &amp; Frequency:</b>

PRESCRIPTION ORDERS	
<b>Anaphylaxis Kit:</b> <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	
<b>Pre-Medications:</b> <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
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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	<b>Loading Dose</b>	
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	NONE
	<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	
	<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	
PNH and aHUS	<b>Maintenance Dose</b>	
	<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	
PNH, aHUS and gMG	<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	
	<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"/> 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

