

# Ultomiris Referral Form

Fax completed form to: 833-908-1122



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	
<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 - 10units/mL ---OR--- 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>	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV infusion as needed	Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply)	Diphenhydramine _____ mg IV infusion as needed	NS Hydration 500 ml IV infusion over 30 minutes as needed	Other
<b>Pre-Medications:</b>	Acetaminophen _____ mg PO _____ minutes prior to infusion	Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion	
(Check all that apply)	Diphenhydramine _____ mg PO ---OR--- IV infusion _____ minutes prior to infusion	Other	
<b>Supply Orders:</b> 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	<b>Loading Dose</b>			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	<b>Maintenance Dose</b>			_____
	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	Print Name	Date	Prescriber's Signature	Print Name	Date
Dispense as Written			Substitution Permitted		

