

Ultomiris® Referral Form

Fax Completed Form To:

Phone:

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:		City/State/Zip:	
Home Phone:		Cell Phone:	
Secondary Contact:		Work Phone:	
Patient Diagnosis & ICD-10:		☐ Male ☐ Female	
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	
Practice Name:		DEA #:	
Address:		NPI#:	
Office Contact:		City/State/Zip:	
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: ☐ 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			
Pre-Medications: ☐ 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			
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 ☐ 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 and aHUS	☐ 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, aHUS and gMG			
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			
By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider 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