

# Ultomiris® Referral Form

Fax Completed Form To:

Phone:

**Amerita**  
YOUR INFUSION ADVOCATE

| PATIENT INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                             |                                                               |
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| Patient Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Date of Birth:                                                                                                                                                                                                                                                                                                                                                                              |                                                               |
| 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.#:                                                                                                                                                                                                                                                                                                                                                                                      |                                                               |
| Practice Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | DEA #:                                                                                                                                                                                                                                                                                                                                                                                      |                                                               |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | NPI#:                                                                                                                                                                                                                                                                                                                                                                                       |                                                               |
| Office Contact:                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | City/State/Zip:                                                                                                                                                                                                                                                                                                                                                                             |                                                               |
| Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Fax:                                                                                                                                                                                                                                                                                                                                                                                        |                                                               |
| Supervisory Physician (if applicable):                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                             |                                                               |
| PLEASE ATTACH                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                             |                                                               |
| <input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical)<br><input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results<br><input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates)<br><input type="checkbox"/> Line access documentation/verification if applicable                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Vaccine status (any vaccination) and documentation of any recent vaccinations<br><input type="checkbox"/> Clinical documentation on any recent meningococcal infections<br><input type="checkbox"/> Documentation of a meningococcal vaccination<br><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.<br><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<br><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<br>(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<br>(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                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                             |                                                               |
| <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? <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 and Soliris REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                             |                                                               |
| Ultomiris                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>Loading Dose</b><br><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<br><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<br><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<br><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                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                             | NONE                                                          |
| PNH and aHUS                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <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<br><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<br><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, aHUS, gMG and NMOSD                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Maintenance Dose (Start 2 weeks after Loading Dose)</b><br><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<br><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<br><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<br><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, gMG and NMOSD                                                                                                                                                                                                                                                                                                                                                                                                                                         | <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<br><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<br><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 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

