

Ultomiris® Order Form

Fax Completed Form To:

Phone:

Amerita
YOUR INFUSION ADVOCATE

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 and Soliris 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 ☐ 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		NONE
PNH and aHUS			
PNH, aHUS, gMG and NMOSD			
PNH and aHUS	Maintenance Dose (Start 2 weeks after Loading 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 ☐ 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		
PNH, aHUS, gMG and NMOSD			
☐ OTHER			NONE

Prescriber's Signature	Print Name	Date	Prescriber's Signature	Print Name	Date
Dispense as Written			Substitution Permitted		

