

Ultomiris Referral Form



Fax completed form to: _____

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			
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion. 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: (Check all that apply)	Epinephrine 0.3mg IM as needed Diphenhydramine _____ mg IV infusion as needed	Solu-cortef 250mg-500mg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed	Solu-Medrol 60mg - 125mg IV infusion as needed Other
Pre-Medications: (Check all that apply)	Acetaminophen _____ mg PO _____ minutes prior to infusion Diphenhydramine _____ mg PO ---OR--- IV infusion _____ minutes prior to infusion	Solu-Medrol _____ mg 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 over at least 1.4 hours For patients 10-20kg administer 600mg IV infusion over at least 0.8 hours For patients 20-30kg administer 900mg IV infusion over at least 0.6 hours For patients 30-40kg administer 1,200mg IV infusion over at least 0.5 hours		NONE
PNH and aHUS	For patients 40-60kg administer 2,400mg IV infusion over at least 0.8 hours For patients 60-100kg administer 2,700mg IV infusion over at least 0.6 hours For patients >100kg administer 3,000mg IV infusion over at least 0.4 hours		
PNH, aHUS and gMG	Maintenance Dose For patients 5-10kg administer 300mg IV infusion over at least 0.8 hours every 4 weeks For patients 10-20kg administer 600mg IV infusion over at least 0.8 hours every 4 weeks For patients 20-30kg administer 2,100mg IV infusion over at least 1.3 hours every 8 weeks For patients 30-40kg administer 2,700mg IV infusion over at least 1.1 hours every 8 weeks		_____
PNH and aHUS	For patients 40-60kg administer 3,000mg IV infusion over at least 0.9 hours every 8 weeks For patients 60-100kg administer 3,300mg IV infusion over at least 0.7 hours every 8 weeks For patients >100kg administer 3,600mg IV infusion over at least 0.5 hours every 8 weeks		
OTHER			NONE
<i>By signing this form and utilizing our services, you are authorizing EventusRx to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.</i>			

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