

Ultomiris Order 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 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: (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			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			
PNH, aHUS and gMG	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 and aHUS	Maintenance Dose			_____
	For patients 40-60kg administer 2,400mg IV infusion via gravity ---OR--- pump over at least 0.8 hours			
PNH, aHUS and gMG	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			
OTHER	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			
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 _____
 Dispense as Written _____
 Print Name _____
 Date _____

Prescriber's Signature _____
 Substitution Permitted _____
 Print Name _____
 Date _____



ACHC ACCREDITED

