

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
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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
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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 PNH and aHUS PNH, aHUS and gMG	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 and gMG	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 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	Print Name	Date	Prescriber's Signature	Print Name	Date
Dispense as Written			Substitution Permitted		