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
- Solu-Medrol ______mg IV infusion ______minutes prior to infusion
- 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 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 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, aHUS and gMG	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	
	Maintenance Dose	___________
PNH and aHUS	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	
PNH, aHUS and gMG	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 Mosaic to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature **Print Name** **Date**
Dispense as Written

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

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MOS 00 Ultomiris ORDER FORM 06-06-22

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