

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:

Patient Demographics, Most Recent Office Visit Note, Insurance Information, Meningococcal Vaccine, Enrolled in Ultomiris-REMS Program

PATIENT INFORMATIONReferral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): G70.00 G70.01 D59.5 PNH D59.32 aHUS G36.0 NMOSD ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____**PROVIDER INFORMATION**

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- Center will use Hypersensitivity protocol established by Infusion for Health and PI
- Meningococcal Vaccines Conjugate and Serogroup B (list dates of both MenB and MenACWY & attach clinicals)

- Patients and prescribers must be enrolled and certified in the Ultomiris and Soliris REMS

PRE-MEDICATION ORDERS*Pre-Medications not usually indicated.*

- Diphenhydramine 25mg / 50mg PO / IV
- Acetaminophen 325mg / 500mg / 650mg PO
- Other: _____
Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- Other _____ every _____
- Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

- Ultomiris in 0.9% sodium chloride IV Infusion
- Indication: PNH aHUS gMG NMOSD
- Dose:
 - Loading Dose (if patient has already completed loading dose, proceed to maintenance dose).
 - 40 kg to less than 60 kg: 2400 mg
 - 60 kg to less than 100 kg: 2700 mg
 - Greater than 100 kg: 3000mg
 - Maintenance Dose: Starting 2 weeks after the loading dose and then every 8 weeks thereafter
 - 40 kg to less than 60 kg: 3000 mg
 - 60 kg to less than 100 kg: 3300 mg
 - Greater than 100 kg: 3600mg
- Monitor patients for 1 hour after completion of infusion
- Refills: Zero / for 12 months / _____ (if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

Provider Name (Print) _____ Provider Signature _____ Date _____

- Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.