# Ultomiris Order Form

**Fax completed form to:** 405-418-4442

amerita specialty infusion services

mosaic infusion solutions

## 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 ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes 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<br>PNH and aHUS | **Loading Dose**<br>☐ For patients 5-10kg administer 600mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 1.4 hours<br>☐ For patients 10-20kg administer 600mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 0.8 hours<br>☐ For patients 20-30kg administer 900mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 0.6 hours<br>☐ For patients 30-40kg administer 1,200mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 0.5 hours | NONE |
| PNH, aHUS and gMG | ☐ For patients 40-60kg administer 2,400mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 0.8 hours<br>☐ For patients 60-100kg administer 2,700mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 0.6 hours<br>☐ For patients >100kg administer 3,000mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 0.4 hours | |
| PNH and aHUS | **Maintenance Dose**<br>☐ For patients 5-10kg administer 300mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 0.8 hours every 4 weeks<br>☐ For patients 10-20kg administer 600mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 0.8 hours every 4 weeks<br>☐ For patients 20-30kg administer 2,100 IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 1.3 hours every 8 weeks<br>☐ 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<br>☐ For patients 60-100kg administer 3,300mg IV infusion via ☐ gravity ***---OR---*** ☐ pump over at least 0.7 hours every 8 weeks<br>☐ 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**
**Dispense as Written**

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


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