

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ Phone: _____ Allergies: _____
 City, State, Zip: _____ Email: _____

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

Is this the first dose? Yes No, date of last infusion: _____ Line type: PIV PICC Port Other

DIAGNOSIS AND ICD-10 CODE

<input type="checkbox"/> Myasthenia gravis (gMG)	ICD-10 Code: _____
<input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD-10 Code: _____
<input type="checkbox"/> Neuromyelitis Optica Spectrum Disorder (NMOSD)	ICD-10 Code: _____
<input type="checkbox"/> Atypical Hemolytic Uremic Syndrome (aHUS)	ICD-10 Code: _____
<input type="checkbox"/> Diagnosis _____	ICD-10 Code: _____

REQUIRED DOCUMENTATION

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Antibody results (if applicable): Anti-AQP4 for NMOSD, AChR for gMG
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Documentation of meningococcal vaccines
<input type="checkbox"/> H&P and Clinical/Progress notes supporting primary diagnosis	

Is your patient enrolled in the Ultomiris-REMS program? Yes No (must be enrolled to start therapy)
 Is the ordering PROVIDER enrolled in the Ultomiris and Soliris REMS? Yes No (must be enrolled to start therapy)

List Tried & Failed Therapies, including duration of treatment:

1)
2)

MEDICATION ORDERS

Loading Dose Ultomiris _____ mg IV as a single dose
 Maintenance Dose Ultomiris _____ mg IV every _____ weeks, starting 2 weeks after the loading dose
 Infusion rate determined by patient weight in accordance with manufacturer guidelines.

Refills*: None X 6 months X 1 Year Other: _____

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
 RN to flush and lock VAD/CVAD per company protocol
 Other: _____

PREMEDICATION ORDERS

Acetaminophen 650mg PO prior to infusion Other: _____
 Diphenhydramine 25mg PO prior to infusion Other: _____

EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
 Acetaminophen 325mg-650mg PO
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.3mg IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive
 Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (A/C/AIS only)

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
 Diphenhydramine 25mg slow IV push over 2-5 mins
 Acetaminophen 325mg PO
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____
 Office Phone: _____ Office Fax: _____
 Prescriber Signature: _____ Date: _____