VEROS HEALTH
Excellence in Complex Care

Ultomiris® Referral Form

Please complete the following and fax with clinical documentation to: 720.279.7461

Referral Process

1. PATIENT INFORMATION			2. PHYSICIAN INFORMATION		
Name:			Physician's name:		
Address:			License #:	NPI #:	
City:	State:	Zip:	DEA #:		
Home Phone:	Other Phone:		Address:		
Email:			City:	State:	Zip:
DOB:	Social Security #:		Office Contact:		
Gender: ☐ M ☐ F	Height:	Weight:	Phone:	Fax:	

3. DIAGNOSIS Year of diagnosis: _____

☐ Atypical Hemolytic Uremic Syndrome (aHUS) (D59.3) in patients one month or older
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) (D59.5) in patients one month or older

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. ADDITIONAL INFORMATION REQUESTED

Allergies: _____
Patient has received meningococcal vaccine ☐ Yes ☐ No Date Received _____

6. PRESCRIPTION INFORMATION Anticipated Start Date: _____

Ultomiris® (ravulizumab-cwvz)

Loading dose:

☐ (For weight greater than or equal to 5 kg to less than 20 kg) Infuse 600 mg IV as directed
☐ (For weight greater than or equal to 20 kg to less than 30 kg) Infuse 900 mg IV as directed
☐ (For weight greater than or equal to 30 kg to less than 40 kg) Infuse 1200 mg IV as directed
☐ (For weight greater than or equal to 40 kg to less than 60 kg) Infuse 2400 mg IV as directed
☐ (For weight greater than or equal to 60 kg to less than 100 kg) Infuse 2700 mg IV as directed
☐ (For weight greater than or equal to 100 kg) Infuse 3000 mg IV as directed

Maintenance dose: 2 weeks following the loading dose begin doses at once ***every 4-week intervals***

☐ (For weight greater than or equal to **5 kg to less than 10 kg)** Infuse 300 mg IV as directed
☐ (For weight greater than or equal to **10 kg to less than 20 kg**) Infuse 600 mg IV as directed

Maintenance dose: 2 weeks following the loading dose begin doses at once ***every 8-week intervals***

☐ (For weight greater than or equal to 20 kg to less than 30 kg) Infuse 2100 mg IV as directed
☐ (For weight greater than or equal to 30 kg to less than 40 kg) Infuse 2700 mg IV as directed
☐ (For weight greater than or equal to 40 kg to less than 60 kg) Infuse 3000 mg IV as directed
☐ (For weight greater than or equal to 60 kg to less than 100 kg) Infuse 3300 mg IV as directed
☐ (For weight greater than or equal to 100 kg) Infuse 3600 mg IV as directed

# of Refills _____

7. ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.
Pediatrics: administer by age: *For mild reaction (rash/hives) give diphenhydramine*
Age 1-5: 12.5mg IV/PO x1 **Age 6-11**: 25mg IV/PO x1 **Age 12+**: 50mg IV/PO x1
For severe reaction (airway closure) administer epinephrine. 0.01mg/kg/dose (max 0.3mg) SubQ/IM x 1.
If needed, repeat a second dose after 5-10 minutes for a maximum of two doses. Contact 911 and monitor vital signs.

☐ Other: ______________________

Administration Method: ☐ Gravity ☐ Pump   Supplies (if needed per dose): _____

Skilled Nursing Services Needed? ☐ Yes ☐ No   Additional Instructions: _____

Access: ☐ PICC ☐ Central _____   ☐ Peripheral   ☐ Flush per Soleo protocol

Dispense quantity: ________________________________ Refills: _____

7. ☐ Dispense as written ☐ Substitution Permitted

PHYSICIAN'S SIGNATURE (required): _____________________________________ **Date:** _____

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Prescription is valid for one year unless otherwise indicated.

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.