

Ultomiris® Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

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: <input type="checkbox"/> M <input type="checkbox"/> F Height: _____ Weight: _____	Phone: _____ Fax: _____
3. DIAGNOSIS Year of diagnosis: _____ <input type="checkbox"/> Atypical Hemolytic Uremic Syndrome (aHUS) (D59.3) in patients one month or older <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Date Received _____	
6. PRESCRIPTION INFORMATION Anticipated Start Date: _____	
Ultomiris® (ravulizumab-cwvz) <i>Loading dose:</i> <input type="checkbox"/> (For weight greater than or equal to 5 kg to less than 20 kg) Infuse 600 mg IV as directed <input type="checkbox"/> (For weight greater than or equal to 20 kg to less than 30 kg) Infuse 900 mg IV as directed <input type="checkbox"/> (For weight greater than or equal to 30 kg to less than 40 kg) Infuse 1200 mg IV as directed <input type="checkbox"/> (For weight greater than or equal to 40 kg to less than 60 kg) Infuse 2400 mg IV as directed <input type="checkbox"/> (For weight greater than or equal to 60 kg to less than 100 kg) Infuse 2700 mg IV as directed <input type="checkbox"/> (For weight greater than or equal to 100 kg) Infuse 3000 mg IV as directed <i>Maintenance dose:</i> 2 weeks following the loading dose begin doses at once every 4-week intervals <input type="checkbox"/> (For weight greater than or equal to 5 kg to less than 10 kg) Infuse 300 mg IV as directed <input type="checkbox"/> (For weight greater than or equal to 10 kg to less than 20 kg) Infuse 600 mg IV as directed <i>Maintenance dose:</i> 2 weeks following the loading dose begin doses at once every 8-week intervals <input type="checkbox"/> (For weight greater than or equal to 20 kg to less than 30 kg) Infuse 2100 mg IV as directed <input type="checkbox"/> (For weight greater than or equal to 30 kg to less than 40 kg) Infuse 2700 mg IV as directed <input type="checkbox"/> (For weight greater than or equal to 40 kg to less than 60 kg) Infuse 3000 mg IV as directed <input type="checkbox"/> (For weight greater than or equal to 60 kg to less than 100 kg) Infuse 3300 mg IV as directed <input type="checkbox"/> (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.

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