

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Med List 5. Most Recent Labs 6. Tried/Failed Therapies
 7. Is referring provider enrolled in the FDA REMS program? Yes No
 8. Has the patient received the 1st dose of meningococcal vaccine series? Yes No Date: _____
 If not started, check here for infusion clinic to administer vaccine series:

PRIMARY DIAGNOSIS

G70.00 Myasthenia gravis without (acute) exacerbation (gMG) G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
 D59.3 Atypical Hemolytic Uremic Syndrome (aHUS) D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)
 Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

Per infusion clinic protocol: No recommended standard pre-meds for Ultomiris
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Weight 40kg-59kg:
 Ultomiris 2400mg IV at week 0, then Ultomiris 3000mg IV at week 2 and every 8 weeks thereafter
Weight ≥ 100kg:
 Ultomiris 3000mg IV at week 0, then Ultomiris 3600mg IV at week 2 and every 8 weeks thereafter
 Ultomiris _____mg IV every _____weeks Other _____
 FIRST DOSE?: Yes No Refill x12 months unless otherwise noted.

Weight 60kg-99kg:
 Ultomiris 2700mg IV at week 0, then Ultomiris 3300mg IV at week 2 and every 8 weeks thereafter

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____