

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION

Primary ICD-10 Code (Please Specify Diagnosis): _____

Secondary ICD-10 Code (Please Specify Diagnosis): ___ MG-ADL* score (if known): _____

Has the patient received Meningitis vaccination? Yes No Date of vaccination: _____

Please check this box if the patient has declined vaccination Reason: _____

Adverse reactions with previous Ultomiris treatments? No Yes *If yes, Reason/Date:* _____

Is the patient transitioning from Soliris to Ultomiris? No Yes Is the patient going to receive IVIG infusions in addition to Ultomiris? No Yes

Please check to confirm: The patient is enrolled in the ULTOMIRIS REMS program; The patient has been counseled about the risks of meningococcal infection; The patient has received information and a Patient Safety Card about the symptoms and risks of meningococcal infection.

ULTOMIRIS® ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Strength	Dose/Frequency	Refills
Intravenous Ultomiris® (ravulizumab)	<input type="checkbox"/> 1,100mg/11mL vial	<input type="checkbox"/> Loading dose: Begin _____ mg IV on day 1 Then 2 weeks later <input type="checkbox"/> Maintenance dose: Begin _____ mg IV every _____ weeks <input type="checkbox"/> Other: _____	_____
	<input type="checkbox"/> 300mg/3mL vial <input type="checkbox"/> 300mg/30mL vial <input type="checkbox"/> Other: _____		
Subcutaneous Ultomiris® (ravulizumab)	<input type="checkbox"/> 245mg/3.5 mL prefilled cartridge with on body injector	<input type="checkbox"/> 490 mg once weekly in adult patients greater than or equal to 40 kg body weight with PNH or aHUS. <input type="checkbox"/> Other: _____	_____

ANAPHYLACTIC REACTION (AR):

EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary

EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary

Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary

Hydrocortisone 100mg - Give 100 mg IVP -or- IM if no IV access

Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr

Other: _____

SIGNATURE

X _____ Date: _____

Prescriber Signature

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