BioTek reMEDys®

ULTOMIRIS®

Please Fax Completed Form To: 800-783-9146

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

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)	☐ 1,100mg/11mL vial ☐ 300mg/3mL vial ☐ 300mg/30mL vial ☐ Other: _____	☐ Loading dose: Begin _____ mg IV on day 1 **Then 2 weeks later** ☐ Maintenance dose: Begin _____ mg IV every _____ weeks ☐ Other: _____	_____
Subcutaneous Ultomiris® (ravulizumab)	☐ 245mg/3.5 mL prefilled cartridge with on body injector	☐ 490 mg once weekly in adult patients greater than or equal to 40 kg body weight with PNH or aHUS. ☐ 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