ULTOMIRIS® Infusion

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Atypical Hemolytic Uremic Syndrome (aHUS)
_____ Paroxysmal nocturnal hemoglobinuria (PNH)
_____ Other: _____

Please attach the following: 1. Clinical progress notes and H&P to support diagnosis 2. Copy of the patient's Insurance Card 3. Positive Serologic test results if appropriate for diagnosis (e.g. NMOSD or MG) 4. Patient has had the appropriate meningococcal vaccines ◯ Yes ◯ No 5.Prescriber is enrolled in Ultomiris REM Program ◯ Yes ◯ No 6. Was the patient previously receiving Soliris ◯ Yes ◯ No If yes, what was the date of the last dose infuse:_____

Lab Orders: _____

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **ULTOMIRIS® (ravulizumab-cwvz)**

☐ ***PNH*** _____ # Refills (Recommend 5)

☐ ***New Start:*** Infuse _____mg initially followed by _____mg 2 weeks later and then every 8 weeks thereafter

☐ ***Maintenance Dose :*** Infuse _____ mg every 8

☐ ***aHUS*** _____ # Refills (Recommend 5)

☐ ***New Start:*** Infuse _____ mg initially followed by _____ mg 2 weeks later and then every ☐ 4 weeks ☐ 8 weeks thereafter

☐ ***Maintenance Dose:*** Infuse _____ mg every ☐ 4 weeks ☐ 8 weeks thereafter

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO administered 30 min prior to infusion **adjust to patient's needs.*
☐ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date