

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Atypical hemolytic uremic syndrome (aHUS) ICD-10 Code: D59.3 _____
 _____ Paroxysmal nocturnal hemoglobinuria (PNH) ICD-10 Code: D59.5 _____
 _____ Other: _____ ICD-10 Code: _____
 Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
- Patient has had the appropriate meningococcal vaccines YES NO
- Prescriber is enrolled in Ultomiris REM Program YES NO
- Was the patient previously receiving Soliris YES NO
 If yes, what was the date of the last dose infuse: _____

Patient	
Weight: _____	lbs.
Height: _____	in.

Lab Orders: _____

ULTOMIRIS® (ravulizumab-cwvz)

J Code: J1303

4. Drug Order:

PNH _____ # Refills (Recommend 5)

Initial Dose: Infuse _____ mg initially followed by _____ mg 2 weeks later and then every 8 weeks thereafter

Maintenance Dose: Infuse _____ mg every 8 weeks

aHUS _____ # Refills (Recommend 5)

Initial Dose: 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 this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written

Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

<p>FAX ALL INFORMATION CENTRAL FAX 803.999.1754</p>	<p>INFUSION CENTER LOCATIONS BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760</p>
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