# ULTOMIRIS (RAVULIZUMAB)
## Infusion Orders

**PHONE** 515.225.2930 | **FAX** 515.559.2495

## Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

**Patient Name:** ______________________ **DOB:** ____________ **Phone:** ____________

**Patient Status:** New to Therapy Continuing Therapy **Next Treatment Date:** ____________

## Medical Information

Patient weight: ____________ lbs. (required) **Allergies:** ______________________

**Diagnosis:**
- Paroxysmal Nocturnal Hemoglobinuria (PNH) (ICD-10 Code: D59.5)
- Atypical Hemolytic Uremic Syndrome (aHUS) (ICD-10 Code: D59.3)
- Myasthenia Gravis w/out acute exacerbation (gMG) (ICD-10 Code: G70.00)
  - Myasthenia Classification: II III IV
- Other: ____________ (ICD-10 Code: ____________ )

## Therapy Order

**Ultomiris**

Initial dosing with maintenance (new adult patients):

- 40kg-59kg – 2,400 mg IV, followed by 3,000 mg IV 2 weeks later, then 3,000 mg IV every 8 weeks
- 60kg-99kg – 2,700 mg IV, followed by 3,300 mg IV 2 weeks later, then 3,300 mg IV every 8 weeks
- ≥100kg – 3,000 mg IV, followed by 3,600 mg IV 2 weeks later, then 3,600 mg IV every 8 weeks

Maintenance dosing (adult):

- 40kg-59kg – 3,000 mg IV every 8 weeks
- 60kg-99kg – 3,300 mg IV every 8 weeks
- ≥100kg – 3,600 mg IV every 8 weeks

**Refill for:** 6 months 1 year Other: ____________

**Additional orders:** ______________________

**Lab Orders:** ____________ **Frequency:** Every infusion Other: ____________

Required labs to be drawn by: Hy-Vee Health Referring Provider

**Anaphylactic reaction orders:**

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg PO or IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing as applicable

**Flush orders:** NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

## Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

**Provider Name:** ____________ **Signature:** ____________ **Date:** ____________

**Provider NPI:** ____________ **Phone:** ____________ **Fax:** ____________ **Contact Person:** ____________

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): ____________

## Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX Phoenix, AZ Other ____________

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# COMPREHENSIVE SUPPORT FOR ULTOMIRIS THERAPY

## Patient Information

**Patient Name:** ______________________ **DOB:** ______________________

## Required Documentation for Referral Processing & Insurance Approval

Include signed and completed order (MD/prescriber to complete page 1)

Include patient demographic information and insurance information

Include patient's medication list

Include labs and/or test results to support diagnosis

Has the patient had the meningococcal vaccines – both MenACWY and MenB ***(required)***

Yes No

Prescriber is enrolled in the Ultomiris REMS program ***(required)***

Yes No

Supporting clinical notes to include any past tried and/or failed therapies, intolerances, benefits or contraindications to therapy

gMG diagnosis – please answer and/or attach the following:

Does the patient have a positive serologic test for anti-AChR antibodies?

Yes No

If yes, please attach results

Myastenia Gravis-Activities of Daily Living (MG-ADL) score: ______________________

EMG report

aHUS diagnosis – has Shiga toxin E. coli and TTP been ruled out?

Yes No

PNH diagnosis – please answer the following:

Does the patient have GPI protein deficiencies?

Yes No

If yes, please provide flow cytometry analysis: ______________________

Does the patient have a history of failure of, contraindication or intolerance to Empaveli (pegcetacoplan) therapy?

Yes No

Does the patient have the presence of a thrombotic event, organ damage secondary to chronic hemolysis, high LDH activity or is the patient transfusion dependent?

Yes No

Other medical necessity: ______________________

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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