medix infusion

Ultomiris® Order Form
(ravulizumab)

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F

Ht: _____ Wt: _____ ☐ lbs ☐ kg Primary Language: _____

Allergies: _____ Patient Preferred Location: _____

Diagnosis

ICD 10 Code Required

☐ D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)
☐ D59.3 Atypical hemolytic uremic syndrome (aHUS)
☐ G70.00 Myasthenia Gravis w/out acute exacerbation (gMG)
Myasthenia Classification ☐ II ☐ III ☐ IV
☐ G36.00 Neuromyelitis optica spectrum disorder (NMOSD)
☐ Other: _____ (ICD-10 Code: _____

Medication Order

DOSE | DIRECTIONS | DURATION

Initial Dosing with Maintenance (New Adult Patients)

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

Maintenance Dosing (Adult)

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

Is patient currently receiving therapy above from another facility?

☐ YES ☐ NO

If yes, Facility Name: _____

Date of last treatment: _____

PRE-MEDICATION ORDERS

☐ Acetaminophen 650mg PO
☐ Diphenydramine 25mg PO
☐ Methylprednisolone _____ mg IVP
☐ Other: _____

Lab Orders

Requested Add'l Lab Orders:

_____

_____

Lab Frequency: _____every _____weeks

Required Clinical Documentation

☐ Include patient demographic information and insurance information
☐ Include labs and|or test results to support diagnosis
☐ Include patient's medication list
☐ Include signed and completed order (MD/prescriber to complete)
☐ Prescriber is enrolled in the Ultomiris REMS program (**required**) ☐ YES ☐ NO
☐ Has the patient completed the meningococcal vaccine series - both MenACWY and Men B (**required**) ☐ YES ☐ NO
☐ If no, has patient been prescribed prophylactic antibiotic? ☐ 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 antigodies? ☐ YES ☐ NO
    If yes, please attach results _____
    ☐ Myastenia Gravis-Activities of Daily Living (MG-ADL) score
    ☐ EMG report
  ☐ 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, contrandication, 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 transufion dependent? ☐ YES ☐ NO
    ☐ NMOSD diagnosis - Does the patient have a positive serologic test for AQP4 antibodies? ☐ YES ☐ NO If yes, please attach results
☐ Other medical necessity: _____

Medix Infusion will collect all necessary labs if not included in the referral documents

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Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____