BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

ULTOMIRIS (RAVULIZUMAB)
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

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 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 IV every 8 weeks

☐ 60kg to 99kg - 3,300mg IV every 8 weeks

☐ 100kg or greater - 3,600mg 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: ☐ Biocare Infusion ☐ Referring Provider

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or SubQ; may repeat in 5-10 minutes x 1
  - 15-30kg (33-66 lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
- Diphenhydramine: Administer 25-50mg PO or IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing as applicable

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

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

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
  - ☐ Myasthenia 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: _____

Biocare Infusion 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.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance