Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Myasthenia gravis without (acute) exacerbation	ICD 10 Code: G70.00
☐ Myasthenia gravis with (acute) exacerbation	ICD 10 Code: G70.01
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5
☐ Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code: G36.0
☐ Hemolytic-uremic syndrome (aHUS)	ICD 10 Code: D59.3

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis)
*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes supporting primary diagnosis
☐ Documentation of meningococcal vaccines

List Tried & Failed Therapies (if Myasthenia Gravis):
1)
2)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Initial Dosing	☐ J1303 Ultomiris 2,400 mg IV (40kg to less than 60kg) ☐ J1303 Ultomiris 2,700 mg IV (60kg to less than 100 kg) ☐ J1303 Ultomiris 3,000 mg IV (100kg or greater)
Maintenance Dosing	☐ J1303 Ultomiris 3,000 mg (40kg to less than 60kg) IV every 8 weeks starting 2 weeks after initial load ☐ J1303 Ultomiris 3,300 mg (60kg to less than 100 kg) IV every 8 weeks starting 2 weeks after initial load ☐ J1303 Ultomiris 3,600 mg (100kg or greater) IV every 8 weeks starting 2 weeks after initial load

Duration ☐ **None** ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses** ***(if not indicated order will expire one year from date signed)**

Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first does of ULTOMIRIS, unless the risks of delaying ULTOMIRIS therapy outweigh the risk of developing a meningococcal infection. Comply with the most current National Advisory Committee on Immunization (NACI) recommendations for meningococcal vaccination in patients with complement deficiencies.

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

INFUSION ORDERS - ULTOMIRIS (RAVULIZUMAB-cwvz)

Clinics Scan to: Physician Orders