# SOLIRIS / ULTOMIRIS REFERRAL FORM

Date: _____

## Y Medical Associates

**Fax Referral To: 855-838-0623**

**Phone: 800-447-7558**

YMedical ASSOCIATES

### Patient Information

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
DOB: _____ Gender: ☐ M ☐ F

### Prescriber Information

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
DEA: _____ NPI #: _____
Contact Person: _____

## INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug cards)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN#: _____ PCN#: _____ Group: _____

## DIAGNOSIS & CLINICAL ASSESSMENT *(Fill in below or attach lab work)*

☐ New to Therapy ☐ Currently on Therapy ☐ Date of Last IVIG Infusion: _____ ☐ IVIG Dosing Regimen: _____

**Diagnosis**: ☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G70.01 Myasthenia Gravis with (acute) exacerbation ☐in crisis

☐D59.3 atypical Hemolytic Uremic Syndrome (aHUS) ☐D59.5 PNH ☐G36.0 Neuromyelitis Optica **Date of Diagnosis**: _____

**Weight:** _____ **Height:** _____ **Date:** _____ **Allergies:** _____ **Date of MenACWY:** _____ **Date of MenB:**_____

**Previously on PLEX treatment ☐Yes ☐No Date of last treatment:**_____ **Is patient AchR antibody positive? ☐Yes ☐No**
**Is the Patient Anti-Aquaporin-4 (AQP4) antibody positive? ☐Yes ☐No Notes/Comments:** _____

## Soliris (eculizumab)

| Strength | Directions |
|---|---|
| Injection:<br>300mg / 30mL<br>(10mg/mL) in a<br>single-dose vial | ☐ **For treatment of Myasthenia Gravis:**<br>☐ 900mg weekly for the first 4 weeks, followed by ☐ 1200mg for the fifth dose 1 week later, then<br>☐ 1200mg every 2 weeks thereafter.<br>☐ **For treatment of aHUS – 18 years or older:**<br>☐ 900mg weekly for the first 4 weeks, followed by<br>☐ 1200mg for the fifth dose 1 week later, then<br>☐ 1200mg every 2 weeks thereafter.<br>☐ **For treatment of NMOSD:**<br>☐ 900mg weekly for the first 4 weeks, followed by<br>☐ 1200mg for the fifth dose 1 week later, then<br>☐ 1200mg every 2 weeks thereafter.<br>☐ **For treatment of PNH – 18 years or older:**<br>☐ 600mg weekly for the first 4 weeks, followed by ☐ 900mg for the fifth dose 1 week later, then<br>☐ 900mg every 2 weeks thereafter.<br>**Orders and Medications**<br>**Other:**_____ |

## Ultomiris (ravulizumab)

| Strength | Directions |
|---|---|
| Injection:<br>☐ 300mg/30mL<br>(10mg/mL) in a<br>single dose vial<br>☐ 300mg/3 mL<br>(100mg/mL) in a<br>single dose vial<br>☐ 1,100mg/11mL<br>(100mg/mL) in a<br>single dose vial<br>*** Do not mix ULTOMIRIS 100 mg/mL (3mL and 11mL vials) and 10mg/mL (30mL vial) concentrations together.**<br>**When switching therapy: Ultomiris loading dose should be given at the time of next scheduled Soliris dose. | ☐ **For treatment of Myasthenia Gravis - weight based at time of treatment (patient must be at least 40kg):**<br>☐ _____mg as a single dose, followed by<br>☐ _____mg once every 8 weeks later starting 2 weeks after the loading dose.<br>☐ **For treatment of aHUS – weight based at time of treatment:**<br>☐ _____mg as a single dose, followed by<br>☐ _____mg once every ____ (4 or 8) weeks later starting 2 weeks after the loading dose.<br>☐ **For treatment of PNH – weight based at time of treatment:**<br>☐ _____mg as a single dose, followed by<br>☐ _____mg once every ____ (4 or 8) weeks later starting 2 weeks after the loading dose.<br>**Other:**_____ |

**Anaphylaxis Orders**

Diphenhydramine Administer 25 mg slow IV/IM may repeat x1 ***Dispense****: 1 x 50 mg vial*

Epinephrine Autoinjector ☐ Administer 0.15mg (1:2000) IM (< 30 Kg) ☐ Administer 0.3mg (1:1000) IM (≥ 30 Kg) **Dispense**: 1 package (2 pens)

Sodium Chloride 0.9% *Use to maintain IV line, prevent or treat hypotension in case of anaphylaxis* ***Dispense****:* QS

**IV Access Flush Order:**

NaCl 0.9% 5-10ml IV before and after infusion
Heparin 10 Units/ml 5ml after infusion for PICC/Midline Heparin 10 Units/ml 3ml after infusion for PIV
Heparin 100 Units/ml 5ml IV after infusion for PORT
All infusion supplies necessary to administer the medication

| Quantity | _____ | Refills | _____ |
|---|---|---|---|

**Other/Notes**:_____
_____
_____

**Prescriber Signature:** _____ **DAW (Dispense as Written)** ☐ Y ☐ N **Date:** _____