SOLIRIS / ULTOMIRIS REFERRAL FORM

Date: _____

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

Ultomiris (ravulizumab)

Strength	Directions
Injection: ☐ 300mg/30mL (10mg/mL) in a single dose vial ☐ 300mg/3 mL (100mg/mL) in a single dose vial ☐ 1,100mg/11mL (100mg/mL) in a single dose vial *** Do not mix ULTOMIRIS 100 mg/mL (3mL and 11mL vials) and 10mg/mL (30mL vial) concentrations together.** **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):** ☐ _____mg as a single dose, followed by ☐ _____mg once every 8 weeks later starting 2 weeks after the loading dose. ☐ **For treatment of aHUS – weight based at time of treatment:** ☐ _____mg as a single dose, followed by ☐ _____mg once every ____ (4 or 8) weeks later starting 2 weeks after the loading dose. ☐ **For treatment of PNH – weight based at time of treatment:** ☐ _____mg as a single dose, followed by ☐ _____mg once every ____ (4 or 8) weeks later starting 2 weeks after the loading dose. **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:** _____