ADDRESS: 12144 DAIRY ASHFORD RD. SUITE 100 SUGAR LAND, TX 77478

DELIVERIT
Infusion & Specialty

PHONE: (832) 939-8137
FAX: (832) 939-8128

ULTOMIRIS INFUSION ORDERS

☐ **Infused at MDO.**

☐ **Infused at Home.** SET UP OF SKILLED NURSING VISITS REQUIRED.

COMPLETE PATIENT DEMOGRAPHIC INFORMATION IN SECTION BELOW

Or Attach Face Sheet from Patient Chart

Patient Name:		DOB:	Gender: ☐ Male ☐ Female	Weight:	☐ lbs ☐ kg
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip code :	

COMPLETE PATIENT INSURANCE INFORMATION IN THE SECTION BELOW

Or Attach Copies of Patient's Insurance Card

Primary insurance Carrier:	Name of the Insured:	Relationship:
Member ID #:	Group #:	Insurance Phone #:
Secondary Rx Carrier Name:	Rx ID #:	Rx Group #:

MEDICAL INFORMATION

Diagnosis ☐ Paroxysmal nocturnal hemoglobinuria (PNH) ICD-10 Code: _____

☐ Atypical hemolytic uremic syndrome (aHUS) ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs. Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis and including past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy.

Labs Orders: _____

ULTOMIRIS INFUSION ORDERS

PNH and aHUS Diagnosis:

Initial dosing with maintenance (new patients):

☐ 40kg to 59kg - 2,400mg IV loading dose, followed by 3,000mg IV maintenance 2 weeks later, then 3,000mg IV every 8 weeks

☐ 60kg to 99kg - 2,700mg IV loading dose, followed by 3,300mg IV maintenance 2 weeks later, then 3,300mg IV every 8 weeks

☐ 100kg or greater - 3,000mg IV loading dose, followed by 3,600mg IV maintenance 2 weeks later, then 3,600mg IV every 8 weeks

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☐ 60kg to 99kg - 2,700mg IV loading dose, followed by 3,300mg IV maintenance 2 weeks later, then 3,300mg IV every 8 weeks

☐ 100kg or greater - 3,000mg IV loading dose, followed by 3,600mg IV maintenance 2 weeks later, then 3,600mg IV every 8 weeks

Initial dosing with maintenance (new patients):

☐ Yes ☐ No - Patient has had the meningococcal vaccines (both MenACWY and MenB)

☐ Yes ☐ No -Prescriber is enrolled in Ultomiris REMS Program

COMPLETE PRESCRIBER INFORMATION IN SECTION BELOW

Prescriber Name:	NPI#:	Office#:	Fax#:
Address:	City:	State:	Zipcode:

SIGNATURE OF LICENSED PRESCRIBER (REQUIRED TO VALIDATE PRESCRIPTION)

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Prescriber's Signature:

X_____

☐ DAW(Dispense as Written)

Date: _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.