Ultomiris
infusion orders

DELIVERIT™
Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Face Sheet from Patient Chart)

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

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

©2025 DELIVERIT PHARMACY. ALL RIGHTS RESERVED.

Ultomiris
infusion orders

DELIVERIT™
Infusion & Specialty

Phone +1.832.939.8137
Fax: +1.832.939.8128

Prescriber Insurance Information

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip Code	

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

☐ DAW (Dispense as written).

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.

Date

Prescriber's Signature

X ______________________________

©2025 DELIVERIT PHARMACY. ALL RIGHTS RESERVED.