

Ultomiris and Soliris REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049

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1 PATIENT'S INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: MALE FEMALE
 Address: _____ City/State/Zip: _____
 Primary Phone: _____ Email: _____ SSN: _____ Primary Language: _____
 Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

2 INSURANCE (Please attach if Available a copy of the Patients' insurance card(s) Front/ Back)

Primary Insurance: _____ Policy No: _____ Group: _____
 Primary RX Insurance: _____ ID No: _____ RX GRP: _____ RX BIN: _____ RX PCN: _____

3 DIAGNOSIS AND CLINICAL INFORMATION

Patient Clinical Information:

Diagnosis (ICD-10):

- D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH) D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)
 G36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD) G70.0 generalized Myasthenia Gravis (gMG)
 Other Code: _____ Description: _____

Drug Allergies: _____ NKDA Ht: _____ in/cm Wt: _____ lbs/Kg

4 PRESCRIPTION INFORMATION

ACCESS: Intravenous

MEDICATION	STRENGTH	DOSE & DIRECTION	QUANTITY	REFILLS
<input type="checkbox"/> Soliris	<input type="checkbox"/> 300mg Vial	<input type="checkbox"/> LOADING Dose: Administer _____ mg / Dilute _____ ml Soliris in equal volume Normal Saline and infused intravenously once weekly for 4 weeks. Begin maintenance dose 1 week later. Adult: infuse over 35 minutes / Pediatric: infuse over _____ hours	Quantity: Q.S	Refills: 1 YEAR
		<input type="checkbox"/> MAINTENANCE Dose: Administer _____ mg / Dilute _____ ml Soliris in equal volume Normal Saline and infused intravenously every 2 weeks. Adult: infuse over 35 minutes / Pediatric: infuse over _____ hours	Quantity: Q.S	Refills: 1 YEAR
<input type="checkbox"/> Ultomiris	<input type="checkbox"/> 300mg/3ml <input type="checkbox"/> 1100mg/11ml	<input type="checkbox"/> LOADING Dose: Administer _____ mg / Dilute _____ ml Ultomiris in equal volume Normal Saline and infused intravenously on Day 1 over _____ hours.	Quantity: Q.S	Refills: 1 YEAR
		<input type="checkbox"/> MAINTENANCE Dose: Administer _____ mg / Dilute _____ ml Ultomiris in equal volume Normal Saline and infused intravenously over _____ hours at week 2 then every 8 weeks thereafter.	Quantity: Q.S	Refills: 1 YEAR

PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input type="checkbox"/> Diphenhydramine <input type="checkbox"/> PO <input type="checkbox"/> IV	Administer _____ mg 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Acetaminophen (PO)	Administer _____ mg PO 30-60 min Prior to Infusion. May repeat every _____ hours PRN.	Quantity: Q.S	Refills: PRN

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input checked="" type="checkbox"/> EPINEPHRINE (vial or autoinjector)	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes <input type="checkbox"/> 0.3 mg (Wt > 30 kg) <input type="checkbox"/> 0.15 mg (Wt 15-30 kg) <input type="checkbox"/> 0.1 mg (Wt 7.5-15 kg)	Quantity: (x1) Vial or (x2) Pen(s)	Refills: PRN
<input checked="" type="checkbox"/> DIPHENHYDRAMINE (50mg/mL)	Administer via IM or slow IV push for severe anaphylactic reaction. <input type="checkbox"/> 50 mg (Wt > 30 kg) <input type="checkbox"/> 25 mg (Wt 15-30 kg) <input type="checkbox"/> 12.5mg (Wt 7.5-15kg)	Quantity: (x1) Vial(s)	Refills: PRN
<input checked="" type="checkbox"/> SODIUM CHLORIDE 0.9% (IV)	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: Q.S	Refills: PRN

NURSING/ LABS/ INFUSION SUPPLIES:

NURSING: Nursing visits with each infusion to establish SC access, administer medication, assess and monitor patient, provide education, and complete lab draws.

INFUSION SUPPLIES: Infusion supplies for Subcutaneous access, administration, and disposal of medication.

FLUSHING PROTOCOL: Sodium chloride 0.9%, Up to 10 mL mL before/after medication, and/or PRN to maintain patency.

Heparin: 10 Units/mL 100 Units/mL, _____ as final flush and/or PRN to maintain patency

5 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber Name: _____ Title: MD DO ND PA APRN NPI: _____
 Address: _____ City/State/Zip: _____
 Phone: _____ Fax: _____ Contact Person: _____

DISPENSE AS WRITTEN BRAND MEDICALLY NECESSARY DO NOT SUBSTITUTE May Substitute Product Selection Permitted / Substitution Permissible
 NO SUBSTITUTION / DAW / MAY NOT SUBSTITUTE

Prescriber's Signature: _____ Date: _____ Prescriber's Signature: _____ Date: _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language.

Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.

CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to Info@ivsolutionsrx.com and destroy all copies of the original message.

THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE

#welcome to our family