

Ultomiris Enrollment Form



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP Code: _____

Preferred Contact Methods: Phone (primary # provided below) Text (cell # provided below) Email (email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: Male Female

HTWT Collection Date: ___/___/___ Weight: _____ lb kg Height: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP Code: _____

Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: Patient Office Other: _____

Diagnosis (ICD-10):

D59.3 Atypical Hemolytic Uremic Syndrome (aHUS) D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)

Other: _____

Patient Clinical Information:

Has the patient been vaccinated against Neisseria meningitidis: Yes No Date: ___/___/___

Is patient transitioning from Soliris? Yes No If yes, start Ultomiris loading dose two weeks after last Soliris dose

Patient Administration Information:

Patient to be infused: Physician office Home Other: _____

Facility/Address/Contact/Phone#: _____

Is this a first dose? Yes No If yes, where is the patient to be infused for first dose?

MD office with MDO staff Hospital/Clinic Home by home care nurse CVS Specialty® to coordinate skilled nursing to provide home infusion or medication via gravity per home care protocols and provide IV/port access care, flushing per protocol

Other: _____

If infusion requested other than home, are any supplies needed: Yes No

If yes, please specify: _____

Pump infusion required? Yes No (Port IV access only, otherwise administer via gravity)

Specialty Pharmacy to coordinate nursing for home care Yes No

Vascular access: PIV Port Huber Needle size: _____ PICC Other: _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.

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Please Complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION LOADING DOSE	STRENGTH	DOSE & DIRECTIONS	QUANTITY REFILLS
Ultomiris	<input type="checkbox"/> 300 mg/3 mL vial (100 mg/mL) <input type="checkbox"/> 1100 mg/11 mL vial (100 mg/mL)	Loading Dose: Infuse over ____ minutes based on the max infusion rate in the chart referenced below Other: _____	Quantity: 30-day supply of drug and supplies Refills: _____

Loading Dose Infusion Information

Body Weight Range (kg)	Loading Dose (mg)	Ultomiris Volume (mL)	Volume of NaCl Diluent	Total Volume (mL)	Minimum Infusion Time (hr)	Maximum Infusion Rate (mL/hr)
5 to <10	600	6	6	12	1.4	8
10 to <20	600	6	6	12	0.8	16
20 to <30	900	9	9	18	0.6	30
30 to <40	1,200	12	12	24	0.5	46
40 to <60	2,400	24	24	48	0.8	64
60 to 100	2,700	27	27	54	0.6	92
≥ 100	3,000	30	30	60	0.4	144

MEDICATION MAINTENANCE DOSE	STRENGTH	DOSE & DIRECTIONS	QUANTITY REFILLS
Ultomiris	<input type="checkbox"/> 300 mg/3 mL vial (100 mg/mL) <input type="checkbox"/> 1100 mg/11 mL vial (100 mg/mL)	Maintenance Dose: Infuse over ____ minutes based on the max infusion rate in the chart referenced below Frequency of infusion: at week 2 then every 8 weeks thereafter Other: _____	Quantity: 30-day supply of drug and supplies Refills: _____

Maintenance Dose infusion information

Body Weight Range (kg)	Loading Dose (mg)	Ultomiris Volume (mL)	Volume of NaCl Diluent	Total Volume (mL)	Minimum Infusion Time (hr)	Maximum Infusion Rate (mL/hr)
5 to <10	300	3	3	6	0.8	8
10 to <20	600	6	6	12	0.8	16
20 to <30	2,100	21	21	42	1.3	33
30 to <40	2,700	27	27	54	1.1	49
40 to <60	3,000	30	30	60	0.9	65
60 to 100	3,300	33	33	66	0.7	99
≥ 100	3,600	36	36	72	0.5	144

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X _____ X _____

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Prescriber Name: _____ Prescriber Phone: _____

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Pre-medication

Note: If ordering Solu-Medrol, please specify (IVP) IV Push or (IV) piggyback diluted in 100 mL 0.9% Sodium Chloride or D5W

MEDICATIONS	DOSE STRENGTH	DIRECTIONS FREQUENCY	QUANTITY REFILLS
<input type="checkbox"/> Other: _____	Other: _____	Other: _____	Other: _____

SUPPLIES	DOSE STRENGTH ROUTE	DIRECTIONS FREQUENCY	QUANTITY REFILLS
<input type="checkbox"/> EpiPen 0.3 mg (adult) <input type="checkbox"/> Epinephrine 0.3 mg Pen (adult)	0.3 mg	Inject 0.3 mg IM/SQ as needed for allergic reaction. May repeat one time	Quantity: 2 Refills: 0
<input type="checkbox"/> EpiPen Junior 0.15 mg (15-29 kg) <input type="checkbox"/> Epinephrine Jr 0.15 mg (15-29 kg)	0.15 mg	Inject 0.15 mg IM/SQ as needed for allergic reaction. May repeat one time	Quantity: 2 Refills: 0
<input type="checkbox"/> Diphenhydramine	Other: _____	Other: _____	Quantity: ____ Refills: ____
<input type="checkbox"/> Sodium Chl. 0.9% 50 mL bag for administration	(2) 50 mL	Dilute Ultomiris dose with equal amount of sodium chloride 0.9% to a final concentration of 5 mg/mL	Quantity: QS Refills: PRN
<input type="checkbox"/> Sodium Chl. 0.9% 10 mL (flush)	10 mL bag	Use as directed to flush IV line	Quantity: QS Refills: PRN
<input type="checkbox"/> Sterile Sodium Chl. 0.9% 10 mL (flush to access port)	10 mL bag	Access port with 10 mL Sterile, Normal Saline Flush	Quantity: QS Refills: PRN
<input type="checkbox"/> Heparin (flush to lock port)	<input type="checkbox"/> 10 units/mL 5mL <input type="checkbox"/> 100 units/mL 5 mL	Following Ultomiris infusion, flush port with 10 mL Normal Saline, then 5 mL Heparin to lock	Quantity: QS Refills: PRN

Patient is interested in patient support programs

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(Date)

X _____

X _____

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