



Fax Referral To: 1-877-232-5455
 Address: 3375 Koapaka Street, Suite D105, Honolulu, HI 96819

Phone: 1-808-254-2727
 NCPDP: 1203417

Ultomiris Prescription Order/Nursing Order

First Dose to be given in controlled setting (ex/ CORAM AIS)

| 1) PATIENT INFORMATION | | | | | | |
|---|--|------------|-------|-----------------------|---------|----------------|
| First Name: | | Last Name: | | DOB: | Gender: | CVS Account #: |
| Address: | | | City: | | State: | ZIP: |
| Phone: | | Allergies: | | | Weight: | ICD-10: |
| <input type="checkbox"/> Start of treatment | <input type="checkbox"/> Continuation of therapy | | | Requested Start Date: | | |

| 2) PRESCRIBER INFORMATION | | | | | |
|---------------------------|-------|--|----------|------|-------------------|
| Prescriber Name: | | | Address: | | City, State, ZIP: |
| NPI # | DEA # | | Phone: | Fax: | |

| 3) SERVICE LOCATION | | | | | |
|--|---|--|--------|------|----------|
| <input type="checkbox"/> CORAM AIS first and then HOME | * (Use if getting first dose and eventually want home infusion) * | | | | |
| <input type="checkbox"/> Home Infusion Only | <input type="checkbox"/> Coram AIS Only | | | | |
| Address: | | | | | Contact: |
| City: | | | State: | ZIP: | Ph# |

| 4a) PRESCRIPTION INFORMATION – LOADING DOSE | | | | | | |
|---|---|--|-----------------|-----------|-------------------------|-----------|
| Medication & Strength | Dose & Directions | | | Quantity | Refills | |
| Ravulizumab (Ultomiris) | <input type="checkbox"/> 300mg/3ml Vial | <input type="checkbox"/> Loading Dose: Dilute [checked dose from below chart] ml of Ultomiris in an equal volume of Normal Saline and infuse intravenously on Day 1 over ____ hours (based on the maximum infusion rate in the chart below). Administer maintenance dose 2 weeks later. | | | Quantity: 14-day supply | 0 Refills |
| | <input type="checkbox"/> 1100mg/11ml Vial | | | | Quantity: 14-day supply | 0 Refills |
| | | <input type="checkbox"/> Other (Loading Dose): _____ | Quantity: _____ | 0 Refills | | |

| Loading Dose Infusion Information (Check appropriate dose) | | | | | | |
|--|-------------------|-----------------------------|------------------------|-------------------|----------------------------|-------------------------------|
| 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 | <input type="checkbox"/> 6 | 6 | 12 | 1.4 | 9 |
| 10 to <20 | 600 | <input type="checkbox"/> 6 | 6 | 12 | 0.8 | 15 |
| 20 to <30 | 900 | <input type="checkbox"/> 9 | 9 | 18 | 0.6 | 30 |
| 30 to <40 | 1,200 | <input type="checkbox"/> 12 | 12 | 24 | 0.5 | 48 |
| 40 to <60 | 2,400 | <input type="checkbox"/> 24 | 24 | 48 | 0.8 | 60 |
| 60 to < 100 | 2,700 | <input type="checkbox"/> 27 | 27 | 54 | 0.6 | 90 |
| ≥ 100 | 3,000 | <input type="checkbox"/> 30 | 30 | 60 | 0.4 | 150 |

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4b) PRESCRIPTION INFORMATION – MAINTENANCE DOSE

| Medication & Strength | | Dose & Directions | Quantity | Refills |
|-------------------------|---|--|-------------------------|----------|
| Ravulizumab (Ultomiris) | <input type="checkbox"/> 300mg/3ml Vial | <input type="checkbox"/> Maintenance Dose: Dilute [checked dose from below chart] ml of Ultomiris in an equal volume of Normal Saline and infuse intravenously over ____ hours (based on the maximum infusion rate in the chart below) every 8 weeks. | Quantity: 56-day supply | Refills: |
| | <input type="checkbox"/> 1100mg/11ml Vial | | Quantity: 56-day supply | Refills: |
| | | <input type="checkbox"/> Maintenance Dose: Dilute [checked dose from below chart] ml of Ultomiris in an equal volume of Normal Saline and infuse intravenously over ____ hours (based on the maximum infusion rate in the chart below) every 4 weeks. *Typical dosing frequency for patients under 20 kg* | Quantity: ____ | Refills: |
| | | <input type="checkbox"/> Other (Maintenance Dose): ____ | Quantity: ____ | Refills: |

Maintenance Dose Infusion Information (Check appropriate dose)

| Body Weight Range (kg) | Maintenance 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 | <input type="checkbox"/> 3 | 3 | 6 | 0.8 | 8 |
| 10 to <20 | 600 | <input type="checkbox"/> 6 | 6 | 12 | 0.8 | 15 |
| 20 to <30 | 2,100 | <input type="checkbox"/> 21 | 21 | 42 | 1.3 | 33 |
| 30 to <40 | 2,700 | <input type="checkbox"/> 27 | 27 | 54 | 1.1 | 50 |
| 40 to <60 | 3,000 | <input type="checkbox"/> 30 | 30 | 60 | 0.9 | 67 |
| 60 to < 100 | 3,300 | <input type="checkbox"/> 33 | 33 | 66 | 0.7 | 95 |
| ≥ 100 | 3,600 | <input type="checkbox"/> 36 | 36 | 72 | 0.5 | 144 |

5) Complete below if Home Infusion or Coram AIS administration

| | |
|-----------------------------------|--|
| Catheter | Catheter Care – flush only on drug admin days – SASH or PRN to maintain IV access & patency |
| PIV (default if no selection) | PIV – NS 5ml (Heparin 10 units/ml 3-5ml if multiple days) |
| Port | Port – NS 10mL & Heparin 100 units/ml 3-5ml |
| PICC: # Lumens | PICC – NS 10ml & Heparin 100 units/ml 3-5ml + Maintenance flushes per lumen |
| Other: | |
| *Give as PIV if Port/PICC failure | |

6) PREMEDICATIONS (Home Infusion or Coram AIS administration)

| | | | |
|----------------------------------|---------------------------------------|--------------------------|--|
| Diphenhydramine 25mg capsules | 25mg PO 30 minutes prior to infusion | Quantity: 1 per infusion | Refills to match prescription(s) above |
| | 50mg PO 30 minutes prior to infusion | Quantity: 2 per infusion | Refills to match prescription(s) above |
| Acetaminophen 325mg tablets | 325mg PO 30 minutes prior to infusion | Quantity: 1 per infusion | Refills to match prescription(s) above |
| | 650mg PO 30 minutes prior to infusion | Quantity: 2 per infusion | Refills to match prescription(s) above |
| Medication: | Directions: | Quantity: | Refills to match prescription(s) above |
| Medication: | Directions: | Quantity: | Refills to match prescription(s) above |
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| PATIENT INFORMATION | | | | |
|---------------------|------------|------|---------|----------------|
| First Name: | Last Name: | DOB: | Gender: | CVS Account #: |

| 7a) Acute Infusion Reaction Medications – Home Infusion | | | | |
|--|--|-------------|--|--|
| Please fill out below if going to be infused at HOME and patient requires any other medication besides Epinephrine: | | | | |
| Epinephrine autoinjectors | Adult (>30kg): 0.3mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes | Quantity: 2 | RF: 0 | |
| Epinephrine autoinjectors | Pediatric (>15-30 kg): 0.15mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes | Quantity: 2 | RF: 0 | |
| *Pharmacy to determine dose based on patient weight (above). Leave on file if patient has in-date epinephrine on hand* | | | | |
| Medication: | Directions: | Quantity: | Refills to match prescription(s) above | |
| Medication: | Directions: | Quantity: | Refills to match prescription(s) above | |
| Medication: | Directions: | Quantity: | Refills to match prescription(s) above | |

| 7b) Acute Infusion Reaction Medications – Coram AIS (Coram AIS will provide drug and supplies for the below if MD prescribes) | | | | |
|---|--|---|--|--|
| Please fill out below if going to be infused at CORAM and patient requires any other medication besides Epinephrine: | | | | |
| Epinephrine 1mg/ml amp (1:1000) | Adult (>30kg): 0.3mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes | Refills to match prescriptions(s) above | | |
| Epinephrine 1mg/ml amp (1:1000) | Pediatric (>15-30 kg): 0.15mg PRN severe allergic reaction. Call 911. May repeat in 5-15 minutes | Refills to match prescriptions(s) above | | |
| *CORAM AIS to determine dose based on patient weight (above)* | | | | |
| Diphenhydramine 50mg/1ml vial | Directions: | Refills to match prescription(s) above | | |
| Diphenhydramine oral Liquid 12.5mg/5ml | Directions: | Refills to match prescription(s) above | | |
| Acetaminophen oral | Directions: | Refills to match prescription(s) above | | |
| Methylprednisolone univial (adult) 125mg | Directions: | Refills to match prescription(s) above | | |
| Methylprednisolone univial (pediatric) 40mg | Directions: | Refills to match prescription(s) above | | |
| NaCl 0.9% 10ml PFS | Directions: | Refills to match prescription(s) above | | |
| 500ml NS with rate flow admin set | Directions: | Refills to match prescription(s) above | | |
| Hydrocortisone univial (adult) 250mg | Directions: | Refills to match prescription(s) above | | |
| Hydrocortisone univial (pediatric) 100mg | Directions: | Refills to match prescription(s) above | | |

| 8) Vaccination/Antibiotic Details | | | | |
|--|-------------------------|-----------|------------|----------------|
| Patient is required to complete or update meningococcal vaccination at least 2 weeks prior to the first dose of Ultomiris to comply with the most current Advisory Committee on Immunization Practice (ACIP) recommendations for patients receiving complement inhibitors* | | | | |
| MenACWY | | | | |
| | First Dose Date: _____ | | | |
| | Menveo: | Menactra: | MenQuadfi: | Other/Unknown: |
| | Second Dose Date: _____ | | | |
| | Menveo: | Menactra: | MenQuadfi: | Other/Unknown: |
| MenB | | | | |
| | First Dose Date: _____ | | | |

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| | | |
|--------------------------------|-----------|----------------|
| Bexsero: | Trumenba: | Other/Unknown: |
| Second Dose Date: _____ | | |
| Bexsero: | Trumenba: | Other/Unknown: |
| Third Dose Date: _____ | | |
| Bexsero: | Trumenba: | Other/Unknown: |

MenABCWY

| | | |
|--------------------------------|----------------|--|
| First Dose Date: _____ | | |
| Penbraya: | Other/Unknown: | |
| Second Dose Date: _____ | | |
| Penbraya: | Other/Unknown: | |

Unvaccinated

| |
|-------------------------------|
| Scheduled Vaccine Date: _____ |
|-------------------------------|

Antibacterial Prophylaxis required if patient has not completed vaccination 2 weeks prior to therapy*

| |
|--|
| Antibacterial Drug Prophylaxis Start Date: _____ |
|--|

Clinical Rationale if Not Fully Vaccinated:

Preparation and Administration

- Prior to administration, verify AIR medications are available at the site of infusion.
- Note that patients are at risk of an infusion reaction with each infusion. AIR medications are required for ALL mAB infusions.
- Validate patient's weight and review potential adverse reactions with patient.
- Do not begin preparation until IV access has been established and or patency confirmed.
- Venous Access - Peripheral unless otherwise specified in manufacturer information or patient has pre-existing central access.
- Validate that oral pre-medications have been taken prior to mixing medication.
- Verify all injectable pre-medications are available and ready to administer prior to mixing medication.
- Prior to dilution, visually inspect the solution in the vials; the solution should be free of any particulate matter or precipitation. Do not use if there is evidence of particulate matter, precipitation or discoloration.
- Withdraw the calculated volume of Ultomiris from the appropriate number of vials and dilute in an infusion bag using 0.9% Sodium Chloride to a final concentration of 50mg/ml.
- Mix product gently, do not shake.
- Prior to administration, allow the admixture to adjust to room temperature and administer the prepared solution immediately following preparation.
- Refer to manufacturer guidelines for filtering and administration device information.
- After administration, flush the entire line with 0.9% Sodium Chloride
- Monitor the patient for at least 1 hour after infusion is complete for signs and symptoms of an infusion reaction.

Rx includes related diluents, pumps, DME, ancillary supplies (e.g., needles, syringes, dressings) as necessary for drug administration/catheter maintenance and nursing services for drug administration/therapy teach train or catheter maintenance.

If HOME Infusion – all drugs and supplies including pump if needed is sent.

If CORAM AIS Infusion –No AIR medications are needed to be sent. Send all other supplies including any premeds to CORAM AIS. If pump is required for infusion - no pump is needed to be sent– only send 1) Curlin tubing 2) Pump sheet to nursing homecare to send with these orders

Additional Notes: _____



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| | |
|--|---|
| "Dispense As Written"/Brand Medically Necessary/Do Not Substitute/ No Substitution/ DAW/May Not Substitute | May Substitute/Product Selection Permitted/ Substitution Permissible |
| Prescriber's Signature: _____ Date: _____ | Prescriber's Signature: _____ Date: _____ |
| CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words " No Substitution ": _____ | |
| ATTN: New York and Iowa providers, please submit electronic prescription | |

MD Agent/Title Issuing Order _____

Date & Time _____

RPh Name Receiving Verbal Order _____

Verify Read Back – Initials _____

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