CVS specialty®
Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982 **NCPDP:** 4026325

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:**
☐ Start of treatment	☐ Continuation of therapy	**Requested Start Date:**		

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

3) SERVICE LOCATION	
☐ CORAM AIS first and then HOME	* (Use if getting first dose and eventually want home infusion) *
☐ Home Infusion Only	☐ Coram AIS Only

Address:		Contact:	
City:	State:	ZIP:	Ph#

4a) PRESCRIPTION INFORMATION – LOADING DOSE

Medication & Strength		Dose & Directions	Quantity	Refills
Ravulizumab (Ultomiris)	☐300mg/3ml Vial	☐ **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
	☐1100mg/11ml Vial		Quantity: 14-day supply	0 Refills
		☐ **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	☐6	6	12	1.4	9
10 to <20	600	☐6	6	12	0.8	15
20 to <30	900	☐9	9	18	0.6	30
30 to <40	1,200	☐12	12	24	0.5	48
40 to <60	2,400	☐24	24	48	0.8	60
60 to < 100	2,700	☐27	27	54	0.6	90
≥ 100	3,000	☐30	30	60	0.4	150

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4b) PRESCRIPTION INFORMATION – MAINTENANCE DOSE

Medication & Strength		Dose & Directions	Quantity	Refills
Ravulizumab (Ultomiris)	☐300mg/3ml Vial	☐ **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:
	☐1100mg/11ml Vial		Quantity: 56-day supply	Refills:
		☐ **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:
		☐ **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	☐3	3	6	0.8	8
10 to <20	600	☐6	6	12	0.8	15
20 to <30	2,100	☐21	21	42	1.3	33
30 to <40	2,700	☐27	27	54	1.1	50
40 to <60	3,000	☐30	30	60	0.9	67
60 to < 100	3,300	☐33	33	66	0.7	95
≥ 100	3,600	☐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				
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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: _____

	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.

<u>If HOME Infusion</u> – all drugs and supplies including pump if needed is sent.

<u>If CORAM AIS Infusion</u> –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 Prescriber's Signature: _____ Date: _____	May Substitute/Product Selection Permitted/ Substitution Permissible 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 _____**