11162 Renner Blvd, Lenexa, KS 66219
Fax Form To: 1-800-571-3995 Phone: 800-360-0520 ext. 103-6993
Email Form To: Customer.ServiceFax@CVSHealth.com

Prescription Order / Nursing Order

PATIENT INFORMATION				
Needs by Date:		CVS Account #:		
First Name:	Last Name:	DOB:	Gender:	
Address:	City:	State:	ZIP:	
Phone: Alt. Phone:	If Minor, Parent/Caregiver/Guardian Name (Last, First):			

PRESCRIBER INFORMATION			
Prescriber Name:	Address:	City, State, ZIP:	
NPI:	DEA #:	Phone:	Fax:
Contact Person:		Contact's Phone:	

DIAGNOSIS AND CLINICAL INFORMATION		
Primary Diagnosis:	☐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)
Height:	Weight:	Collection Date:
Allergies:		
Patient is required to have a meningitis vaccine at least two weeks prior to starting therapy.	☐Vaccinated Date:	
	☐Scheduled Date:	

SERVICE LOCATION			
☐Start of Treatment ☐Switch from Soliris to Ultomiris (First dose in a controlled setting is recommended)			
☐Continuation of Therapy (Select maintenance dose location only)			
First Dose Location:	☐Coram AIS (Drug, Diluents, Supplies, and Nursing for drug administration)		
	☐MD Office ☐Other: (Drug Only for facility administration)		
Address:		Contact:	
City:	State:	ZIP:	Ph#:
Maintenance Dose Location:	☐Home Infusion ☐Coram AIS (Drug, Diluents, Supplies, and Nursing for drug administration)		
	☐MD Office ☐Other: (Drug Only for facility administration)		
Address:		Contact:	
City:	State:	ZIP:	Ph#:

SOLIRIS PRESCRIPTION INFORMATION				
Soliris 300mg Vial	☐Loading Dose	mg / Dilute ml Soliris in equal volume Normal Saline and infuse intravenously once weekly for 4 weeks. Begin maintenance dose 1 week later. Adult: infuse over 35 minutes / Pediatric: infuse over hours	Quantity: 28-day supply	Refills:
	☐Maintenance Dose	mg / Dilute ml Soliris in equal volume Normal Saline and infuse intravenously every 2 weeks. Adult: infuse over 35 minutes / Pediatric: infuse over hours	Quantity: 28-day supply	Refills:

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ULTOMIRIS PRESCRIPTION INFORMATION

Ultomiris	☐300mg/3ml Vial	**Loading Dose:** Dilute [checked dose from below chart] ml Ultomiris in equal volume Normal Saline and infuse intravenously on Day 1 over hours (based on the maximum infusion rate in the chart below). Maintenance dose to follow 2 weeks later.	Quantity: 14-day supply	Refills:
	☐1100mg/11ml Vial		Quantity: 14-day supply	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	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

Ultomiris	☐300mg/3ml Vial	**Maintenance Dose:** Dilute [checked dose from below chart] ml Ultomiris in equal volume Normal Saline and infuse intravenously over hours (based on the maximum infusion rate in the chart below). Frequency of infusion: at week 2 then every 8 weeks thereafter.	Quantity: 56-day supply	Refills:
	☐1100mg/11ml Vial		Quantity: 56-day supply	Refills:

Maintenance 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	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

Complete below if Home Infusion or Coram AIS administration ONLY

☐PIV (default if no selection)	
☐Port	**Port** – Pump, NS 10mL & Heparin 100 units/ml 3-5ml
☐PICC: # Lumens	**PICC** – NS 10ml & Heparin 100 units/ml 3-5ml + Maintenance flushes per lumen
*Give as PIV if Port/PICC failure	

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PREMEDICATIONS (Home Infusion or Coram AIS administration ONLY)			
☐ 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
☐ Medication:	Directions:	Quantity:	Refills to match prescription(s) above

Acute Infusion Reaction Medications (Home Infusion or Coram AIS ONLY)			
☐ EpiPen 0.3 mg (adult)	Inject 0.3 mg IM/SQ as needed for allergic reaction. May repeat one time.	Quantity: 2	Refills:
☐ Epinephrine 0.3 mg (adult)	Inject 0.3 mg IM/SQ as needed for allergic reaction. May repeat one time.	Quantity: 2	Refills:
☐ EpiPen Junior 0.15mg (15-29 kg)	Inject 0.15 mg IM/SQ as needed for allergic reaction. May repeat one time.	Quantity: 2	Refills:
☐ Epinephrine Jr 0.15 mg (15-29 kg)	Inject 0.15 mg IM/SQ as needed for allergic reaction. May repeat one time.	Quantity: 2	Refills:

SUPPLIES			
☐ Sodium Chloride 0.9% bag for dilution: 50ml, 100ml, 250ml (pharmacy to select required volume based on mixing requirements)	Dilute dose with equal amount of 0.9% sodium chloride for administration.	Quantity: QS	Refills: PRN
☐ Sodium Chloride 0.9% 10 ml (flush)	Use as directed per flushing protocol.	Quantity: QS	Refills: PRN
☐ Sterile Sodium Chl. 0.9% 10 ml (flush to access port)	Access port with 10 ml Sterile Normal Saline Flush.	Quantity: QS	Refills: PRN
☐ Heparin 100 units/ml, 5ml (flush to lock port)	Following infusion, flush port with 10ml Normal Saline, then 5 ml Heparin to lock.	Quantity: QS	Refills: PRN
☐ Heparin 10 units/ml, 5ml (flush to lock port)	Following infusion, flush port with 10ml Normal Saline, then 5 ml Heparin to lock.	Quantity: QS	Refills: PRN

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.
- Diluent and preparation per manufacturer guidelines.
- 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.
- Infuse per manufacturer guidelines.
- All mABs administered intravenously shall be administered by a nurse.
- Refer to manufacturer guidelines for filtering and administration device information.
- Soliris must be diluted to a final admixture concentration of 5 mg/mL prior to administration.
- Ultomiris must be diluted to a final admixture concentration of 50 mg/mL prior to administration.
- Soliris/Ultomiris admixture should be administered by intravenous infusion. Do not administer as an intravenous push or bolus.
- Ultomiris utilizes a weight-based dosage regimen.
- Nurse shall monitor the patient for 1 hour after infusion is complete and perform a final set of VS at the end of that hour.

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Rx includes related diluents, pumps, DME, ancillary supplies (e.g., needles, syringes, dressings) as necessary for drug administration and nursing services for drug administration.

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 pre-meds to CORAM AIS. If pump is required for infusion - no pump is needed to be sent– only send 1) Pump sheet to nursing homecare to send with these orders

Additional Notes: _____

"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 _____