

Prescription Order / Nursing Order

PATIENT IN	FORMATION	N												
Needs by Date:					CVS Account #:									
First Name:	First Name: Last N			ame: DOB: Gender:										
Address:					:			State:	ZIP:					
Phone:			If Minor Parant	/Caregiver/Guardian	Namo (Last	Eirct)								
Alt. Phone:			ii Millor, Parent		Name (Last	., Fiistj.								
PRESCRIBER	R INFORMAT	ION												
Prescriber N	Prescriber Name: Address:						City, State, ZIP:							
NPI:	NPI: DEA #:					hone: Fax:								
Contact Per	son:			Con	Contact's Phone:									
DIAGNOSIS	AND CLINIC	AL INFORMA	TION											
Primary Dia	anosis.	D59.	5 Paroxysmal Nocturnal Hemoglobinu		ria (PNH) D59.3 Atypic		9.3 Atypical He	l Hemolytic Uremic Syndrome (aHUS)						
	g110313.	G 36.	0 Neuromyelitis Optica	uromyelitis Optica Spectrum Disorder (NMOSD) G70.0 generalize				d Myasthenia	Gravis (gMG)				
Height:			Weight:	Coll	ection Date	:								
Allergies:														
Patient is re	auired to ba	we a meningit	tis vaccine at least two	weeks prior to starti	tarting therapy									
T atient is re		ive a mennigh		weeks phor to start	ng therapy.		Scheduled	Date:						
SERVICE LO	CATION													
Start of T	Freatment	Switch fro	m Soliris to Ultomiris	(First dose in a	controlled s	etting is	recommende	d)						
Continuation of Therapy (Select maintenance dose location only)														
First Dose Location: Coram AIS (Drug, Diluents, Supplied MD Office Other:				ients, Supplies, and N	s, and Nursing for drug administration)									
					(Drug Only for facility administration)									
Address:								Contact:						
City:			Stat	State: ZIP: Ph#:										
Maintenance Dose Home Infusion Coram AIS (Drug, Diluents, Supplies, and Nursing for drug administration)														
Location: MD Office Other: (Drug Only for facility administration)														
Address:					Contact:									
City:				Stat	State:			ZIP:	Ph#:					
SOLIRIS PRE	SCRIPTION	INFORMATIO												
	Loading Dose		mg / Dilute ml Soliris in equal volume Normal Saline and infuse intravenously once weekly for 4 weeks. Begin maintenance dose 1				Quentitu 2	Quantity: 28-day supply						
Soliris				veek later.										
				Adult: infuse over 35 minutes / Pediatric: infuse over hours										
300mg														
Vial	Maintenance Dose		mg / Dilute	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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PATIENT NAME:					DOB:		CVS ACCOUNT	CVS ACCOUNT #:			
ULTOMIRIS PF	RESCRIPT	TION INFORMATION									
Ultomiris	☐300mg/3ml Vial ☐1100mg/11ml 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				Quantity: 14-day supply		Refills:	
Offormins				maximum i		the chart below). N		Quantity: supply	Quantity: 14-day supply		
Loading Dose	Infusion	Information (Check ap	oprop	riate dose)						_	
Body Weight Range (kg) Loading Dose (mg)		;)	Ultomiris Volume (ml)		Volume of NaCl Diluent	Total Volum	Total Volume (ml)		Maximum Infusion Rate (ml/hr)		
5 to <10		600		6		6	12	12		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		2,400		24		24	48		0.8	60	
60 to < 100 2,700		2,700		27		27	54		0.6	90	
≥ 100 3,000		3,000		30		30	60		0.4	150	
Ultomiris	omiris		intenance Dose: Dilute [checked dose from below omiris in equal volume Normal Saline and infuse in the mours (based on the maximum infusion ration). Frequency of infusion: at week 2 then every 8 reafter.			e intravenously n rate in the chart	ate in the chart		Refills: Refills:		
Maintenance	Dose Inf	usion Information (Ch						sabb.)			
Maintenance Dose Infusion Information (Check ap Body Weight Range (kg) Loading Dose (mg)			Volume (ml)	Volume of NaCl Diluent	Total Volum	Minimum Total Volume (ml) Infusion Time (hr)		Maximun 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	
Complete belo	ow if Ho	me Infusion or Coram	AIS ac	Iministration	ONLY						
PIV (defaul	t if no se	lection)									
Port PICC: # Lumens					Port – Pump, NS 10mL & Heparin 100 units/ml 3-5ml PICC – NS 10ml & Heparin 100 units/ml 3-5ml + Maintenance flushes per lumen						
	aanc				DICC - NIS 10ml	& Honarin 100 un	itc/ml 2 5ml + Mair	stonanco flu	choc nor lumo	n	

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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

PATIENT NAME:		DOB:	CVS ACCOU	CVS ACCOUNT #:			
PREMEDICATIONS (Home Infusion or C	oram AIS adminis	stration ONLY)					
Medication:	Directions:		Quantity:	Refills to	match prescripti	on(s) above	
Medication:	Directions:		Quantity:	Refills to match prescription(s) above			
Medication:	Directions:		Quantity:	Refills to match prescription(s) abov			
Medication:	Medication: Directions:			Refills to match prescription(s) above			
Acute Infusion Reaction Medications (I	lome Infusion or	Coram AIS ONLY)					
EpiPen 0.3 mg (adult)	Inject 0.3	Inject 0.3 mg IM/SQ as needed for allergic reaction. May repeat one time.				Refills:	
Epinephrine 0.3 mg (adult)	Inject 0.3	mg IM/SQ as needed for allergic rea	Quantity: 2	Refills:			
EpiPen Junior 0.15mg (15-29 kg)	Inject 0.15	mg IM/SQ as needed for allergic re	Quantity: 2	Refills:			
Epinephrine Jr 0.15 mg (15-29 kg)	Inject 0.15	mg IM/SQ as needed for allergic re	Quantity: 2	Refills:			
SUPPLIES							
Sodium Chloride 0.9% bag for dilutio 50ml, 100ml, 250ml (pharmacy to selec required volume based on mixing requirements)	t	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 dir	Use as directed per flushing protocol.				Refills: PRN	
Sterile Sodium Chl. 0.9% 10 ml (flush access port)	to Access po	Access port with 10 ml Sterile Normal Saline Flush.				Refills: PRN	
Heparin 100 units/ml, 5ml (flush to le port)	ck Following to lock.	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 lo port)	ck Following to lock.	Following infusion, flush port with 10ml Normal Saline, then 5 ml Heparin to lock.				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.

<u>If CORAM AIS Infusion</u> –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	May Substitute/Product Selection Permitted/				
Substitute/ No Substitution/ DAW/May Not Substitute	Substitution Permissible				
Prescriber's Signature:	Prescriber's Signature:				
Date:	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 _____

RPh Name Receiving Verbal Order

Date & Time _____

Verify Read Back – Initials

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