

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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