Ultomiris Enrollment Form

Fax Referral To: 1-800-323-2445
Email Referral To: customer.servicefax@cvshealth.com

Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________ Address: ___________________ City, State, ZIP Code: _____________________

Preferred Contact Methods: ☐ Phone (primary # provided below) ☐ Text (cell # provided below) ☐ Email (email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____________ Alternate Phone: _____________ DOB: _____________ Gender: ☐ Male ☐ Female

HTWT Collection Date: ___/___/___ Weight: _________ ☐ lb ☐ kg Height:_________

Email: _____________________________ Last Four of SSN: _____________ Primary Language: __________________

2 PRESCRIBER INFORMATION

Prescriber's Name: _____________________________ State License #: ____________________________________

NPI #: ____________ DEA #: ____________ Group or Hospital: ____

Address: ____________________________________ City, State, ZIP Code: ___________________________________

Phone: _______________ Fax_______________ Contact Person: _____________ Contact's Phone: ______________

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: ______ Ship to: ☐ Patient ☐ Office ☐ Other: _________

Diagnosis (ICD-10):

☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS) ☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)

☐ Other: ____

Patient Clinical Information:

Has the patient been vaccinated against Neisseria meningitidis: ☐ Yes ☐ No Date: ___/___/___

Is patient transitioning from Soliris? ☐ Yes ☐ No If yes, start Ultomiris loading dose two weeks after last Soliris dose

Patient Administration Information:

Patient to be infused: ☐ Physician office ☐ Home ☐ Other: ________________

Facility/Address/Contact/Phone#:_________________________________

Is this a first dose? ☐ Yes ☐ No If yes, where is the patient to be infused for first dose?

☐ MD office with MDO staff ☐ Hospital/Clinic ☐ Home by home care nurse ☐ CVS Specialty® to coordinate skilled nursing to provide home infusion or medication via gravity per home care protocols and provide IV/port access care, flushing per protocol

☐ Other: ____

If infusion requested other than home, are any supplies needed: ☐ Yes ☐ No

If yes, please specify: ____

Pump infusion required? ☐ Yes ☐ No (Port IV access only, otherwise administer via gravity)

Specialty Pharmacy to coordinate nursing for home care ☐ Yes ☐ No

Vascular access: ☐ PIV ☐ Port Huber Needle size: ______ ☐ PICC ☐ Other: _________________

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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Please Complete Patient and Prescriber information

Patient Name: ____________________ Patient DOB: ____________________

Prescriber Name: ____________________ Prescriber Phone: ____________________

5 PRESCRIPTION INFORMATION

MEDICATION LOADING DOSE	STRENGTH	DOSE & DIRECTIONS	QUANTITY | REFILLS
Ultomiris	☐ 300 mg/3 mL vial (100 mg/mL) ☐ 1100 mg/11 mL vial (100 mg/mL)	Loading Dose: Infuse over ____ minutes based on the max infusion rate in the chart referenced below Other: __________	Quantity: 30-day supply of drug and supplies Refills: __________

Loading Dose Infusion Information

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

MEDICATION MAINTENANCE DOSE	STRENGTH	DOSE & DIRECTIONS	QUANTITY | REFILLS
Ultomiris	☐ 300 mg/3 mL vial (100 mg/mL) ☐ 1100 mg/11 mL vial (100 mg/mL)	Maintenance Dose: Infuse over ____ minutes based on the max infusion rate in the chart referenced below Frequency of infusion: at week 2 then every 8 weeks thereafter Other: __________	Quantity: 30-day supply of drug and supplies Refills: __________

Maintenance Dose infusion information

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

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X____

DISPENSE AS WRITTEN (Date)

X____

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Prescriber Name: ______________________ Prescriber Phone: ______________________

5 PRESCRIPTION INFORMATION

Pre-medication

Note: If ordering Solu-Medrol, please specify (IVP) IV Push or (IV) piggyback diluted in 100 mL 0.9% Sodium Chloride or D5W

MEDICATIONS	DOSE | STRENGTH	DIRECTIONS | FREQUENCY	QUANTITY | REFILLS
☐ Other: __________	Other: ___________	Other: __________________	Other: _______

SUPPLIES	DOSE | STRENGTH | ROUTE	DIRECTIONS | FREQUENCY	QUANTITY | REFILLS
☐ EpiPen 0.3 mg (adult) ☐ Epinephrine 0.3 mg Pen (adult)	0.3 mg	Inject 0.3 mg IM/SQ as needed for allergic reaction. May repeat one time	Quantity: 2 Refills: 0
☐ EpiPen Junior 0.15 mg (15-29 kg) ☐ Epinephrine Jr 0.15 mg (15-29 kg)	0.15 mg	Inject 0.15 mg IM/SQ as needed for allergic reaction. May repeat one time	Quantity: 2 Refills: 0
☐ Diphenhydramine	Other: ______	Other: ________________________	Quantity: _____ Refills: _______
☐ Sodium Chl. 0.9% 50 mL bag for administration	(2) 50 mL	Dilute Ultomiris dose with equal amount of sodium chloride 0.9% to a final concentration of 5 mg/mL	Quantity: QS Refills: PRN
☐ Sodium Chl. 0.9% 10 mL (flush)	10 mL bag	Use as directed to flush IV line	Quantity: QS Refills: PRN
☐ Sterile Sodium Chl. 0.9% 10 mL (flush to access port)	10 mL bag	Access port with 10 mL Sterile, Normal Saline Flush	Quantity: QS Refills: PRN
☐ Heparin (flush to lock port)	☐ 10 units/mL 5mL ☐ 100 units/mL 5 mL	Following Ultomiris infusion, flush port with 10 mL Normal Saline, then 5 mL Heparin to lock	Quantity: QS Refills: PRN

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

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X____

DISPENSE AS WRITTEN (Date)

X____

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