



A Carelon Company

ULTOMIRIS (RAVULIZUMAB) INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

Allergies:

Diagnosis Code ICD-10 (required):

Diagnosis Description:

Patient Status: New to Therapy Continuing Therapy

Next Treatment Date:

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:		Email:	
Address:		City:	State: ZIP:
NPI #:	DEA#:	Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Ultomiris (ravulizumab)	<input type="checkbox"/> 2,400mg IV, followed by 3,000mg IV 2 weeks later, then 3,000mg IV every 8 weeks <input type="checkbox"/> 2,700mg IV, followed by 3,300mg IV 2 weeks later, then 3,300mg IV every 8 weeks <input type="checkbox"/> 3,000mg IV, followed by 3,600mg IV 2 weeks later, then 3,600mg IV every 8 weeks <input type="checkbox"/> 3,000mg IV every 8 weeks <input type="checkbox"/> 3,300mg IV every 8 weeks <input type="checkbox"/> 3,600mg IV every 8 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____

Required labs to be drawn by Paragon Healthcare Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X

Date:

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Include labs and/or test results to support diagnosis
- Prescriber is enrolled in the Ultomiris REMS program (**required**) Yes No
- Supporting clinical notes to include any past tried and/or failed therapies, intolerances, benefits, or contraindications to therapy
 - gMG diagnosis - please answer and/or attach the following:
 - Does the patient have a positive serologic test for anti-AChR antibodies? Yes No
If yes, please attach results
 - Myasthenia Classification: II III IV
 - Myasthenia Gravis-Activities of Daily Living (MG-ADL) score _____
 - EMG report
 - aHUS diagnosis - has Shiga toxin E. coli and TTP been ruled out? Yes No
 - PNH diagnosis - please answer the following:
 - Does the patient have GPI protein deficiencies? Yes No - If yes, please provide flow cytometry analysis
 - Does the patient have a history of failure of, contraindication, or intolerance to Empaveli (pegcetacoplan) therapy? Yes No
 - Does the patient have the presence of a thrombotic event, organ damage secondary to chronic hemolysis, high LDH activity or is the patient transfusion dependent? Yes No
 - NMOSD diagnosis - Does the patient have a positive serologic test for AQP4 antibodies?
 Yes No If yes, please attach results
- Other medical necessity: _____

REQUIRED PRE-SCREENING

- Has the patient had both meningococcal vaccines (MenACWY and Men B)?** Yes No
- Attach proof of meningococcal vaccines - both vaccines are required prior to therapy**