PARAGON HEALTHCARE

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: ☐ Female ☐ Male	
Address:		City:	State:		ZIP:
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ 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)	Loading dose with maintenance: ☐ (40-59kg) 2,400mg IV, followed by 3,000mg IV 2 weeks later, then 3,000mg IV every 8 weeks ☐ (60-99kg) 2,700mg IV, followed by 3,300mg IV 2 weeks later, then 3,300mg IV every 8 weeks ☐ (100kg+) 3,000mg IV, followed by 3,600mg IV 2 weeks later, then 3,600mg IV every 8 weeks Maintenance: ☐ (40-59kg) 3,000mg IV every 8 weeks ☐ (60-99kg) 3,300mg IV every 8 weeks ☐ (100kg+) 3,600mg IV every 8 weeks ☐ Other: _____	☐ x 1 year ☐ _____

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:**

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COMPREHENSIVE SUPPORT FOR ULTOMIRIS (RAVULIZUMAB) THERAPY

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