Please fax both pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Intravenous Ultomiris® (ravulizumab)

accredo®

677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name ______ Last name ______ Middle initial ______

Sex at birth: ☐ Male ☐ Female Pronouns ______ Last 4 digits of SSN ______ Date of birth ______

Street address ______ Apt # ______

City ______ State ______ Zip ______

Home phone ______ Cell phone ______ Email address ______

Parent/guardian (if applicable) ______

Home phone ______ Cell phone ______ Email address ______

Alternate caregiver/contact ______

Home phone ______ Cell phone ______ Email address ______

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify ______

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed ______

Office/clinic/institution name ______

Prescriber info: Prescriber's first name ______ Last name ______

Prescriber's title ______ If NP or PA, under direction of Dr. ______

Office phone ______ Fax ______ NPI # ______ License # ______

Office contact and title ______ Office contact email ______

Office street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

- -

Infusion info: Infusion site name ______ Clinic/hospital affiliation ______

Site street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion site contact ______ Phone ______ Fax ______ Email ______

3 Clinical Information

Primary ICD-10 code (REQUIRED): ☐ **D59.5 Paroxysmal nocturnal hemoglobinuria** ☐ **D59.3 Hemolytic-uremic syndrome** ☐ **D59.32 Hereditary hemolytic-uremic syndrome** ☐ **D59.39 Other hemolytic uremic syndrome** ☐ **G70.00 Myasthenia gravis without (acute) exacerbation** ☐ **G70.01 Myasthenia gravis with (acute) exacerbation** ☐ **Other** ______

MG-ADL* score (if known) ______ Weight ______ kg/lbs Height ______ cm/in Date recorded ______

☐ NKDA ☐ Known drug allergies ______

Concurrent meds ______

Adverse reactions with previous Ultomiris treatments? ______

Date of last Meningitis shot ______

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions
Ultomiris® (ravulizumab)	☐ 1,100mg/11mL vial (100mg/mL) ☐ 300mg/3mL vial (100mg/mL)	Loading dose: Begin _____mg IV on day 1 **Then 2 weeks later** Maintenance dose: Begin _____mg IV every _____ weeks Infusion method: ☐ Gravity ☐ Pump ☐ Other directions, please list here: _____
Dilution and infusion rate	Loading dose: Dilute Ultomiris with Normal Saline as directed per manufacturer guidelines to a final concentration of 50mg/mL **Infusion rate:** As directed per manufacturer guidelines _____ ☐ If different, list here _____ Maintenance dose: Dilute Ultomiris with Normal Saline as directed per manufacturer guidelines to a final concentration of 50mg/mL **Infusion rate:** As directed per manufacturer guidelines _____ ☐ If different, list here _____	

☐ Other instructions: _____

Complete the below section if assistance from Accredo is requested in the coordination of your patient's infusion therapy

Is Accredo home nursing service requested: ☐ Yes ☐ No Vascular access: ☐ Peripheral ☐ Central ☐ Port

Supplies: (please strike through if not required)
Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
PERIPHERAL Access:
0.9% Normal Saline 3mL intravenous before and after infusion, or as needed for line patency.
☐ If different, please list here _____
PORT/CENTRAL Access:
0.9% Normal Saline 5mL intravenous before and after infusion, or as needed for line patency. Heparin 10 units per mL 5mL intravenous as needed for final flush.
☐ If different, please list here _____

Is your patient new to therapy? ☐ Yes ☐ No

Hypersensitivity/Anaphylaxis
Stop infusion
Medicate with:
Epinephrine 0.3mg Auto Injector – Stop infusion and inject dose per packaging for hypersensitivity/anaphylaxis (patient weighs greater than or equal to 30kg) **OR** Epinephrine JR 0.15mg/0.3mL Auto injector – Stop infusion and inject dose per packaging for hypersensitivity/anaphylaxis (patient weighs 15kg to 29kg)

Premedications: Prescriber, please list any premedication(s) you want your patient to have.
Drug _____ Directions _____
Drug _____ Directions _____

Quantity/Refills: Dispense quantity sufficient for medication days supply for loading dose, then 1 dose ongoing for maintenance dose. Refill x 1 year.
☐ Other _____

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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