COASTAL INFUSION SERVICES

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Soliris (eculizumab) I Ultomiris (ravulizumab) Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. **Required Documentation,** please submit the following with form:
   - Copy of insurance card
   - History & Physical
   - Patient demographics
   - Antibody results (if applicable): Anti-AQP4 for NMOSD, or AChR for gMG
   - REMS Requirement: Meningococcal vaccination documentation (see below)

2. **Patient Information**
   ☐Male ☐Female Height: _____ ☐in ☐cm Weight: _____ ☐lbs ☐kg ☐NKDA Allergies: _____
   Is this the first dose? ☐Yes ☐No, date of last infusion: _____ Next due (or desired start date): _____
   Line type: ☐PIV ☐PICC ☐Port ☐Other: _____

REMS Requirement: Meningococcal Vaccination Assessment

Please provide meningococcal vaccination history below **or** send records, this is a REMS requirement:

STEP 1: Meningococcal primary vaccination status (serogroups A, C, W, Y, and B)

MenACWY	MenB	MenABCWY
1st dose date: _____ ☐Menveo ☐Menactra ☐MenQuadfi	1st dose date: _____ ☐Bexsero ☐Trumenba	1st dose date: _____ ☐Penbraya
2nd dose date: _____ ☐Menveo ☐Menactra ☐MenQuadfi	2nd dose date: _____ ☐Bexsero ☐Trumenba	2nd dose date: _____ ☐Penbraya
	3rd dose date: _____ (Trumenba only)	

STEP 2: Antibiotic prophylaxis (if needed): Prophylaxis administered? ☐No ☐Yes, start date: _____
STEP 3: Dates of last booster doses (if applicable): ☐N/A MenACWY: _____ MenB: _____

3. **Diagnosis and Clinical Information: ICD-10** (required): _____ **Diagnosis:** _____
   ☐Atypical Hemolytic Uremic Syndrome (**aHUS**)
   ☐Neuromyelitis Optica Spectrum Disorder (**NMOSD**)
   ☐Myasthenia Gravis (**gMG**)
   ☐Paroxysmal Nocturnal Hemoglobinuria (**PNH**)

4. **Prescription Information** **For Adults ≥40 kg. **For <40 kg provide appropriate dose per indication under "Other"*

☐**ULTOMIRIS (100 mg/mL vials)**		☐**SOLIRIS (10 mg/mL vials)**	
* ☐**Loading Dose:** Infuse _____ mg IV on day 0.	* ☐**Maintenance Dose:** Infuse_____ mg IV every 8 weeks. Start 2 weeks after loading dose.	*☐**Loading Dose:** Infuse _____ mg IV weekly for the first 4 weeks, followed by _____ mg for the 5th week.	*☐**Maintenance Dose:** Infuse _____ mg IV every 2 weeks. Start 2 weeks after the 5th week's dose is complete.
Infuse via 0.2-0.22 micron filter. Flush IV line with NS post-infusion.			
****Other:** _____			
Directions	Prepare product for infusion per manufacturer guidelines using compatible IV solution Infuse at rate directed in manufacturer guidelines, as tolerated (OR over _____hour(s) _____min)		
Quantity / Refills	Dispense 1 month supply / Refill x 12 months OR ☐Other: _____ Dispense all medical supplies necessary for infusion		

5. **Additional Orders**
   RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per Coastal Infusion Services Policy and Procedure
   RN to monitor patient at least 1 hour post infusion, educate on possible side effects, allergic reactions, & when to contact physician

6. **Adverse Reaction Orders:** Standard anaphylaxis kit to be dispensed and dosed per protocol: Epinephrine IM/SQ (1 mg/mL vial), diphenhydramine IV/IM (50 mg/mL vial), and NS IV. Additional orders: _____

7. **Prescriber Information**
   Prescriber Name: _____ Office Contact: _____
   Address: _____ City: _____ State: _____ Zip: _____
   Phone: _____ Fax: _____
   License #: _____ DEA #: _____ NPI: _____

_____ _____ _____ _____
Physician Signature (Substitution Permitted) **Date** **Physician Signature (Dispense as Written)** **Date**

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. Coastal Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.