

# Soliris (eculizumab) | 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: \_\_\_\_\_

**EMS 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
1 <sup>st</sup> dose date: _____ <input type="checkbox"/> Menveo <input type="checkbox"/> Menactra <input type="checkbox"/> MenQuadfi		1 <sup>st</sup> dose date: _____ <input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba	1 <sup>st</sup> dose date: _____ <input type="checkbox"/> Penbraya
2 <sup>nd</sup> dose date: _____ <input type="checkbox"/> Menveo <input type="checkbox"/> Menactra <input type="checkbox"/> MenQuadfi		2 <sup>nd</sup> dose date: _____ <input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba	2 <sup>nd</sup> dose date: _____ <input type="checkbox"/> Penbraya
		3 <sup>rd</sup> 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)
- Myasthenia Gravis (gMG)
- Neuromyelitis Optica Spectrum Disorder (NMOSD)
- Paroxysmal Nocturnal Hemoglobinuria (PNH)

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

<input type="checkbox"/> ULTOMIRIS (100 mg/mL vials)	<input type="checkbox"/> SOLIRIS (10 mg/mL vials)
* <input type="checkbox"/> <b>Loading Dose:</b> Infuse _____ mg IV on day 0.  Infuse via 0.2-0.22 micron filter. Flush IV line with NS post-infusion.	* <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse _____ mg IV every 8 weeks. Start 2 weeks after loading dose.
* <input type="checkbox"/> <b>Loading Dose:</b> Infuse _____ mg IV weekly for the first 4 weeks, followed by _____ mg for the 5 <sup>th</sup> week.	* <input type="checkbox"/> <b>Maintenance Dose:</b> Infuse _____ mg IV every 2 weeks. Start 2 weeks after the 5 <sup>th</sup> week's dose is complete.
**Other: _____	
<b>Directions</b>	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)
<b>Quantity / Refills</b>	Dispense 1 month supply / Refill x 12 months OR <input type="checkbox"/> 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.*

Confidential Health Information: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization and under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. Important Warning: This message is intended for the use of the person or entity to who it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any discrimination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.