

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
1 st dose date: _____ ☐ Menveo ☐ Menactra ☐ MenQuadfi		1 st dose date: _____ ☐ Bexsero ☐ Trumenba	1 st dose date: _____ ☐ Penbraya
2 nd dose date: _____ ☐ Menveo ☐ Menactra ☐ MenQuadfi		2 nd dose date: _____ ☐ Bexsero ☐ Trumenba	2 nd dose date: _____ ☐ Penbraya
		3 rd 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"

☐ 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 5 th week.	* ☐ Maintenance Dose: Infuse _____ mg IV every 2 weeks. Start 2 weeks after the 5 th 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.

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