ULTOMIRIS ORDER

Please complete ALL fields and fax to 817-553-1393. An incomplete form will delay the processing/scheduling of the patient. Thank you for your referral and allowing us to partner with you in the care of your patient. Please call 817-553-1325 with any questions.

Patient's Name:_____ **DOB**_____
Weight(lbs): _____ **Primary Diagnosis**_____
ICD- 10 Code: _____ **Allergies:** _____

Please send all of the following items to complete your referral to 817-553-1393:

- ❑ This completed order form
- ❑ Patient demographics and insurance information
- ❑ Any relevant documentation, scans and labs supporting diagnosis.
- ❑ Copy of Meningitis vaccination record

MENINGITIS VACCINATIONS:

_____MenACWY-2 doses at least 8 weeks apart. A single booster every 5 years.
+
_____MenB-4C: 2 doses at least 1 month apart. A single booster dose 1 year after primary series and every 2-3 years.
OR
_____MenB-FHbp: 3 doses 0,1-2, and 6 months. A single booster dose 1 year after primary series and then every 2-3 years.

CHOOSE ONE	BODY WEIGHT(KG)	LOADING DOSE (2 WEEKS AFTER LAST SOLIRIS INFUSION)	MAINTENANCE DOSE (2 WEEKS AFTER LOADING DOSE)	THEN INFUSE EVERY 8 WEEKS AFTER MAINTANENCE DOSE
	40 TO <60Kg	ULTOMIRIS 2400 MG	3000 MG	3000 MG
	60 TO <100Kg	ULTOMIRIS 2700 MG	3300 MG	3300 MG
	100Kg OR GREATER	ULTOMIRIS 3000 MG	3600 MG	3600 MG

1. START PIV (OR) -FLUSH LINE WITH 10 ML SODIUM CHLORIDE 0.9% AND 5 ML BEFORE AND AFTER INFUSION.
2. INFUSE PER PROTOCOL.
3. OBSERVE ONE HOUR AFTER INFUSION COMPLETION.

Ordering Provider Information

Name _____
Address _____
_____
NPI # _____
Signed _____

Office Contact Information

Name _____
Phone ( ) _____-_____
Fax ( ) _____-_____
Email _____
Date _____ /_____ /_____