Ultomiris Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445
Email Referral To: customer.servicefax@cvshealth.com
Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
HTWT Collection Date: ___/___/___ Weight: _____ ☐ lb ☐ kg Height:_____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____Fax_____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):
☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS) ☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)
☐ G70.0 Generalized Myasthenia Gravis (gMG) - confirm anti-AChR antibody positive ☐
☐ Other: _____

Patient Clinical Information:
Has the patient been vaccinated against Neisseria meningitidis: ☐ Yes ☐ No Date: ___/___/___
Is patient transitioning from Soliris? ☐ Yes ☐ No If yes, start Ultomiris loading dose two weeks after last Soliris dose

Patient Administration Information:
Patient to be infused: ☐ Physician office ☐ Home ☐ Other: _____
Facility/Address/Contact/Phone#:_____
Is this a first dose? ☐ Yes ☐ No If yes, where is the patient to be infused for first dose?
☐ MD office with MDO staff ☐ Hospital/Clinic ☐ Home by home care nurse ☐ CVS Specialty® to coordinate skilled nursing to provide home infusion or medication via gravity per home care protocols and provide IV/port access care, flushing per protocol
☐ Other: _____
If infusion requested other than home, are any supplies needed: ☐ Yes ☐ No
If yes, please specify: _____
Pump infusion required? ☐ Yes ☐ No (Port IV access only, otherwise administer via gravity)
Specialty Pharmacy to coordinate nursing for home care ☐ Yes ☐ No
Vascular access: ☐ PIV ☐ Port Huber Needle size: _____ ☐ PICC ☐ Other: _____

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION LOADING DOSE	STRENGTH	DOSE & DIRECTIONS	QUANTITY | REFILLS
Ultomiris	☐ 300 mg/3 mL vial (100 mg/mL) ☐ 1100 mg/11 mL vial (100 mg/mL)	Loading Dose: Infuse over ____ minutes based on the max infusion rate in the chart referenced below Other: _____	Quantity: 30-day supply of drug and supplies Refills: _____

Loading Dose Infusion Information

Body Weight Range (kg)	Loading Dose (mg)	Ultomiris Volume (mL)	Volume of NaCl Diluent	Total Volume (mL)	Minimum Infusion Time (hr)	Maximum Infusion Rate (mL/hr)
5 to <10	600	6	6	12	1.4	8
10 to <20	600	6	6	12	0.8	16
20 to <30	900	9	9	18	0.6	30
30 to <40	1,200	12	12	24	0.5	46
40 to <60	2,400	24	24	48	0.8	64
60 to 100	2,700	27	27	54	0.6	92
≥ 100	3,000	30	30	60	0.4	144

MEDICATION MAINTENANCE DOSE	STRENGTH	DOSE & DIRECTIONS	QUANTITY | REFILLS
Ultomiris	☐ 300 mg/3 mL vial (100 mg/mL) ☐ 1100 mg/11 mL vial (100 mg/mL)	Maintenance Dose: Infuse over ____ minutes based on the max infusion rate in the chart referenced below Frequency of infusion: at week 2 then every 8 weeks thereafter Other: _____	Quantity: 30-day supply of drug and supplies Refills: _____

Maintenance Dose infusion information

Body Weight Range (kg)	Loading Dose (mg)	Ultomiris Volume (mL)	Volume of NaCl Diluent	Total Volume (mL)	Minimum Infusion Time (hr)	Maximum Infusion Rate (mL/hr)
5 to <10	300	3	3	6	0.8	8
10 to <20	600	6	6	12	0.8	16
20 to <30	2,100	21	21	42	1.3	33
30 to <40	2,700	27	27	54	1.1	49
40 to <60	3,000	30	30	60	0.9	65
60 to 100	3,300	33	33	66	0.7	99
≥ 100	3,600	36	36	72	0.5	144

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____ Date: _____	**Prescriber's Signature: _____ Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

Pre-medication

Note: If ordering Solu-Medrol, please specify (IVP) IV Push or (IV) piggyback diluted in 100 mL 0.9% Sodium Chloride or D5W

MEDICATIONS	DOSE | STRENGTH	DIRECTIONS | FREQUENCY	QUANTITY | REFILLS
☐ Other: _____	Other: _____	Other: _____	Other: _____

SUPPLIES	DOSE | STRENGTH | ROUTE	DIRECTIONS | FREQUENCY	QUANTITY | REFILLS
☐ EpiPen 0.3 mg (adult) ☐ Epinephrine 0.3 mg Pen (adult)	0.3 mg	Inject 0.3 mg IM/SQ as needed for allergic reaction. May repeat one time	Quantity: 2 Refills: 0
☐ EpiPen Junior 0.15 mg (15-29 kg) ☐ Epinephrine Jr 0.15 mg (15-29 kg)	0.15 mg	Inject 0.15 mg IM/SQ as needed for allergic reaction. May repeat one time	Quantity: 2 Refills: 0
☐ Diphenhydramine	Other: _____	Other: _____	Quantity: _____ Refills: _____
☐ Sodium Chl. 0.9% 50 mL bag for administration	(2) 50 mL	Dilute Ultomiris dose with equal amount of sodium chloride 0.9% to a final concentration of 5 mg/mL	Quantity: QS Refills: PRN
☐ Sodium Chl. 0.9% 10 mL (flush)	10 mL bag	Use as directed to flush IV line	Quantity: QS Refills: PRN
☐ Sterile Sodium Chl. 0.9% 10 mL (flush to access port)	10 mL bag	Access port with 10 mL Sterile, Normal Saline Flush	Quantity: QS Refills: PRN
☐ Heparin (flush to lock port)	☐ 10 units/mL 5mL ☐ 100 units/mL 5 mL	Following Ultomiris infusion, flush port with 10 mL Normal Saline, then 5 mL Heparin to lock	Quantity: QS Refills: PRN

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