



MOUNTAIN GRACE
HOME INFUSION

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ULTOMIRIS

Date of order: _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Update Order ☐ Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): ☐ G70.00 ☐ G70.01 ☐ D59.5 PNH ☐ D59.32 aHUS ☐ G36.0 NMOSD ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: info@managecaresolutions.com

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- ☒ Center will use Hypersensitivity protocol established by Mountain Grace Home Infusion and PI
- ☒ Meningococcal Vaccines Conjugate and Serogroup B (list dates of both MenB and MenACWY & attach clinicals): _____
- ☒ For gMG diagnosis: AChR Antibodies (list results and attach clinicals): _____
- ☒ For NMOSD diagnosis: AQP4 Antibodies (list results and attach clinicals): _____
- ☒ Patients and prescribers must be enrolled and certified in the Ultomiris and Soliris REMS

PRE- MEDICATION ORDERS

Pre-meds not usually indicated

- ☐ Diphenhydramine ☐ 25mg / ☐ 50 mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650 mg PO
- ☐ Other: _____
- Dose: _____ Route: _____ Frequency: _____

THERAPY ADMINISTRATION

- ☒ Ultomiris in 0.9% sodium chloride ☒ IV Infusion
- Indication:** ☐ PNH ☐ aHUS ☐ gMG ☐ NMOSD
- Dose:**
 - ☐ Loading Dose (if patient has already completed loading dose, proceed to maintenance dose).
 - ☐ 40 kg to less than 60 kg: 2400 mg
 - ☐ 60 kg to less than 100 kg: 2700 mg
 - ☐ Greater than 100 kg: 3000mg
 - ☐ Maintenance Dose: Starting 2 weeks after the loading dose and then every 8 weeks thereafter
 - ☐ 40 kg to less than 60 kg: 3000 mg
 - ☐ 60 kg to less than 100 kg: 3300 mg
 - ☐ Greater than 100 kg: 3600mg
 - ☐ Monitor patients for 1 hour after completion of infusion
 - ☐ Refills: ☐ Zero/ ☐ for 12 months/ ☐ _____
(if not indicated order will expire one year from date signed)
- To receive the brand-name medication, the prescribing provider must clearly write "Brand Medically Necessary" on the prescription. If this notation is absent, I4H may dispense an FDA-approved generic equivalent or biosimilar, when available.*

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other: _____ ☐ Frequency: _____
- ☐ Please check this box if you DO NOT authorize Mountain Grace Home Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

Provider Name (Print) : _____

Provider Signature : _____

Date : _____

Please send it to this email: info@mginfusion.com