



**Birmingham, AL**  
F: 205-271-9971

**Huntsville, AL**  
F: 256-417-6408

**Knoxville, TN**  
F: 865-934-0249

**Nashville, TN**  
F: 615-645-4791

**Chantilly, VA**  
F: 703-935-2061

**PREVIOUS ADMINISTRATION**

**Please provide the following information:** Last Infusion Date: \_\_\_\_\_ Next Infusion Date: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Is the patient Diabetic: Y N ICD-10 Code: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Primary Diagnosis:** \_\_\_\_\_ Atypical Hemolytic Uremic Syndrome (aHUS)  
 \_\_\_\_\_ Paroxysmal nocturnal hemoglobinuria (PNH)  
 \_\_\_\_\_ Other: \_\_\_\_\_

**Please attach the following:** 1. Clinical progress notes and H&P to support diagnosis 2. Copy of the patient's Insurance Card 3. Positive Serologic test results if appropriate for diagnosis (e.g. NMOSD or MG) 4. Patient has had the appropriate meningococcal vaccines Yes No  
 5. Prescriber is enrolled in Ultomiris REM Program Yes No 6. Was the patient previously receiving Soliris Yes No If yes, what was the date of the last dose infuse: \_\_\_\_\_  
 Lab Orders: \_\_\_\_\_

**Physician Information**

Prescribing Physician: \_\_\_\_\_ Practice Name: \_\_\_\_\_  
 Practice Phone: \_\_\_\_\_ Practice Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Co-managing Physician: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

**Medication Order**

**Medication: ULTOMIRIS® (ravulizumab-cwvz)**

**PNH** \_\_\_\_\_ # Refills (Recommend 5)

**New Start:** Infuse \_\_\_\_\_ mg initially followed by \_\_\_\_\_ mg 2 weeks later and then every 8 weeks thereafter

**Maintenance Dose :** Infuse \_\_\_\_\_ mg every 8

**aHUS** \_\_\_\_\_ # Refills (Recommend 5)

**New Start:** Infuse \_\_\_\_\_ mg initially followed by \_\_\_\_\_ mg 2 weeks later and then every 4 weeks 8 weeks thereafter

**Maintenance Dose:** Infuse \_\_\_\_\_ mg every 4 weeks 8 weeks thereafter

**Pre-Medication Orders:** Acetaminophen 650 mg PO administered 30 min prior to infusion \*adjust to patient's needs.  
 Other: \_\_\_\_\_

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

\_\_\_\_\_  
 Physician's NPI#

\_\_\_\_\_  
 Physician's Address

\_\_\_\_\_  
 Prescriber's Signature

\_\_\_\_\_  
 Date