Please fax both pages of completed form to your team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Intravenous Ultomiris® (ravulizumab)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name ________ Last name ________ Middle initial ________

Sex at birth: ☐ Male ☐ Female Preferred pronouns ________ Last 4 digits of SSN ________ Date of birth ________

Street address ________ Apt # ________

City ________ State ________ Zip ________

Home phone ________ Cell phone ________ E-mail address ________

Parent/guardian (if applicable) ________

Home phone ________ Cell phone ________ E-mail address ________

Alternate caregiver/contact ________

Home phone ________ Cell phone ________ E-mail address ________

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify ________

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date ________ Time ________ Date medication needed ________

Office/clinic/institution name ________

Prescriber info: Prescriber's first name ________ Last name ________

Prescriber's title ________ If NP or PA, under direction of Dr. ________

Office phone ________ Fax ________ NPI # ________ License # ________

Office contact and title ________ Office contact e-mail ________

Office street address ________ Suite # ________

City ________ State ________ Zip ________

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name ________ Clinic/hospital affiliation ________

Site street address ________ Suite # ________

City ________ State ________ Zip ________

Infusion site contact ________ Phone ________ Fax ________ E-mail ________

3 Clinical Information

Primary ICD-10 code (REQUIRED): ☐ **D59.5 Paroxysmal nocturnal hemoglobinuria** ☐ **D59.3 Hemolytic-uremic syndrome** ☐ **D59.32 Hereditary hemolytic-uremic syndrome** ☐ **D59.39 Other hemolytic uremic syndrome** ☐ **G70.00 Myasthenia gravis without (acute) exacerbation** ☐ **G70.01 Myasthenia gravis with (acute) exacerbation** ☐ **Other** ________

MG-ADL* score (if known) ________ Weight ________ kg/lbs Height ________ cm/in Date recorded ________

☐ NKDA ☐ Known drug allergies ________

Concurrent meds ________

Adverse reactions with previous Ultomiris treatments? ________

Date of last Meningitis shot ________

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Dose	Directions	Quantity/Refill
☐ Ultomiris® (ravulizumab)	☐ 1,100mg/11mL vial (100mg/mL) ☐ 300mg/3mL vial (100mg/mL)	☐ Loading dose: Begin _____mg IV on day 1 **Then 2 weeks later** ☐ Maintenance dose: Begin _____mg IV every _____ weeks ☐ Other directions, please list here: _____	Loading dose: ☐ Quantity sufficient ☐ No refills Maintenance dose: ☐ 8-week supply ☐ Other _____ Refills _____
Dilution and infusion rate	☐ Loading dose: ☐ Dilute Ultomiris with Normal Saline as directed per manufacturer guidelines to a final concentration of 50mg/mL ☐ **Infusion rate:** As directed per manufacturer guidelines _____ ☐ If different, list here _____ ☐ Maintenance dose: ☐ Dilute Ultomiris with Normal Saline as directed per manufacturer guidelines to a final concentration of 50mg/mL ☐ **Infusion rate:** As directed per manufacturer guidelines _____ ☐ If different, list here _____		
☐ Other instructions: _____			

Complete the below section if assistance from Accredo is requested in the coordination of your patient's infusion therapy

Is Accredo home nursing service requested: ☐ Yes ☐ No Vascular access: ☐ Peripheral ☐ Central ☐ Port

☐ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, IV tubing, etc. to administer Ultomiris. ☐ Prescriber, please check here to authorize prescription items needed and directions for use to home administer Ultomiris such as: Sodium Chloride 0.9% 500mL Note: A different size bag could be dispensed depending on stock availability. ☐ **PERIPHERAL Access**: Sodium Chloride 0.9% flushes 10mL: Flush with 3mL before and after infusion or as needed for line patency. ☐ If different, please list here _____ ☐ **PORT/CENTRAL Access**: Sodium Chloride 0.9% flushes 10mL: Flush with 5mL before and after infusion or as needed for line patency. Heparin flushes 10 units/mL 5mL: Flush with 5mL as needed for final flush. ☐ If different, please list here _____	Quantity: Quantity sufficient for medication days supply Refills: Quantity sufficient for medication days supply
Is your patient new to therapy? ☐ Yes ☐ No	
Hypersensitivity/Anaphylaxis Stop infusion **Medicate with:** ☐ Epipen/Epinephrine 0.3mg Auto Injector – Stop infusion and inject dose per packaging for hypersensitivity/anaphylaxis (patient weighs greater than or equal to 30kg) **OR** ☐ Epipen/Epinephrine JR 0.15mg/0.3mL Auto injector – Stop infusion and inject dose per packaging for hypersensitivity/anaphylaxis (patient weighs 15kg to 29kg)	Quantity: Quantity sufficient for medication days supply Refills: Quantity sufficient for medication days supply
Premedications: Prescriber, please list any premedication(s) you want your patient to have. ☐ None Drug _____ Directions _____ Drug _____ Directions _____	
Nursing Orders _____	
Lab Orders _____	
☐ Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.	

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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Prior Authorization Checklist
Myasthenia Gravis

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients.[1] Coverage criteria may vary by payer.

Referral Form (not required for electronic prescriptions)	
	Completed myasthenia gravis referral form (available at accredo.com)
	Copies of front and back of all medical insurance and prescription benefit cards
Clinical Documents	
	History and Physical (H&P) and progress notes (within past 6 months)[2] Note: Diagnosis of the disorder must be unequivocal
Myasthenia Gravis (MG)	
	Tensilon test results
	Tried and failed medications, or has contraindication to immunosuppressant therapies (e.g., Mestinon®/corticosteroids/azathioprine/cyclosporine/mycophenolate)
	Ongoing immunoglobulin (Ig) treatment must be documented in H&P and progress notes[2]
	Myasthenic Panel (MG Testing)
	History and Physical (H&P) and progress notes presenting acute myasthenic crisis and decompensation (respiratory failure or disabling weakness). Include Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL)
	Clinical assessment that indicates eye muscle weakness, ptosis or swallowing issues
	Medication is prescribed by or in consultation with a neurologist

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.

1. This myasthenia gravis checklist is based on Medicare Part D guidelines and evidence of disease symptoms related to myasthenia gravis.
2. Ongoing management and documentation requirements:
   a. Initial improvement and continued need must be meticulously documented in progress notes
   b. All weaning must be attempted and documented as either amount or frequency

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