Please fax all pages of completed form to your team at 833.951.1686.
To reach your team, call toll-free 800.442.5781.
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®

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 _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

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

Provider will read the following statement: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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 email _____

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 _____ Email _____

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** ☐ **G36.00 Neuromyelitis Optica [Devic] (NMOSD)**
☐ **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? _____

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

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions
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 Infusion method: ☐ Gravity ☐ Pump ☐ Other _____
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: _____

Has the patient received Meningitis vaccination? ☐ Yes ☐ No

MenACWY

1st Dose

Brand: ☐ Menveo ☐ Menactra ☐ MenQuadFi ☐ Other/Unknown

Date of administration: _____

2nd Dose

Brand: ☐ Menveo ☐ Menactra ☐ MenQuadFi ☐ Other/Unknown

Date of administration: _____

MenABCWY

1st Dose

Brand: ☐ Penbraya ☐ Other/Unknown

Date of administration: _____

2nd Dose

Brand: ☐ Penbraya ☐ Other/Unknown

Date of administration: _____

MenB

1st Dose

Brand: ☐ Bexsero ☐ Trumenba ☐ Other/Unknown

Date of administration: _____

2nd Dose

Brand: ☐ Bexsero ☐ Trumenba ☐ Other/Unknown

Date of administration: _____

3rd Dose

Brand: ☐ Bexsero ☐ Trumenba ☐ Other/Unknown

Date of administration: _____

Antibacterial Drug Prophylaxis (if applicable)

Did patient receive antibacterial drug prophylaxis? ☐ Yes ☐ No

Start Date: _____

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

Supplies: (please strike through if not required) Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

PERIPHERAL Access:

0.9% Normal Saline 3mL intravenous before and after infusion, or as needed for line patency.

☐ If different, please list here _____

PORT/CENTRAL Access:

0.9% Normal Saline 5mL intravenous before and after infusion, or as needed for line patency. Heparin 10 units per mL 5mL intravenous as needed for final flush.

☐ If different, please list here _____

Is your patient new to therapy? ☐ Yes ☐ No

Hypersensitivity/Anaphylaxis: Stop infusion

Medicate with: Epinephrine 0.3mg Auto Injector – Stop infusion and inject dose per packaging for hypersensitivity/anaphylaxis (patient weighs greater than or equal to 30kg) **OR** Epinephrine JR 0.15mg/0.3mL Auto injector – Stop infusion and inject dose per packaging for hypersensitivity/anaphylaxis (patient weighs 15kg to 29kg)

Premedications: Prescriber, please list any premedication(s) you want your patient to have.

Drug _____ Directions _____

Drug _____ Directions _____

Quantity/Refills: Dispense quantity sufficient for medication days supply for loading dose, then 1 dose ongoing for maintenance dose. Refill x 1 year.

☐ Other _____

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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