

Please fax both 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](http://MyAccredoPatients.com) to log in or get started.

Prescription & Enrollment Form

# Intravenous Ultomiris® (ravulizumab)



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 \_\_\_\_\_ 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 \_\_\_\_\_

## 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 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	Strength/Formulation	Directions
Ultomiris® (ravulizumab)	1,100mg/11mL vial (100mg/mL) 300mg/3mL vial (100mg/mL)	Loading dose: Begin _____mg IV on day 1 <b>Then 2 weeks later</b> Maintenance dose: Begin _____mg IV every _____ weeks Other directions, please list here: _____
Dilution and infusion rate	Loading dose: Dilute Ultomiris with Normal Saline as directed per manufacturer guidelines to a final concentration of 50mg/mL <b>Infusion rate:</b> 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 <b>Infusion rate:</b> 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

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 \_\_\_\_\_

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.

# 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.<sup>1</sup> Coverage criteria may vary by payer.

Referral Form (not required for electronic prescriptions)	
	Completed myasthenia gravis referral form (available at <a href="https://www.accredo.com">accredo.com</a> )
	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) <sup>2</sup> 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 <sup>2</sup>
	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