Beacon Infusion
Healthcare Services

ULTOMIRIS MEDICATION ORDER

Patient's Name (Last, First, Middle) _____   **DOB:** _____

■ **Diagnosis**   *Some insurance carriers do not approve of aHUS for this medication.*

☐ D59.5   Paroxysmal nocturnal hemoglobinuria [Marchiafava-Micheli]   ☐ D59.3   Hemolytic-uremic syndrome
☐ G70.00   Myasthenia gravis without (acute) exacerbation   ☐ G70.01   Myasthenia gravis with (acute) exacerbation

■ **Details Needed for Authorization**   *Please answer <u>all</u> questions and <u>provide supporting documentation</u>.*

For paroxysmal nocturnal hemoglobinuria (PNH):
- If the patient has PNH, provide results of PNH clone detection by flow cytometry, and baseline values of one or more of the following tests: Serum LDH, hemoglobin level, and packed RBC transfusion requirements.
- Circle the appropriate indication(s) for this patient's therapy: a) thrombotic event   b) organ damage secondary to chronic hemolysis   c) patient is pregnant and potential benefit outweighs potential fetal risk   d) patient is transfusion dependent   e) patient has high LDH with clinical symptoms
- Does the patient have failure on or contraindication to Soliris (eculizumab)? _____

For atypical hemolytic uremic syndrome (aHUS):
- Have you ruled out STEC-HUS, typical HUS, and infection related HUS? _____
- Have you ruled out coexisting diseases or conditions, S. pneumonia, Influenza A H1N1 or cobalamin deficiency? _____
- Have you ruled out thrombocytopenic purpura (TTP)? _____
- Provide baseline values of the following: LDH, serum creatinine/eGFR, platelet count, and plasma exchange/infusion requirement.
- Does the patient have failure on or contraindication to Soliris (eculizumab)? _____

For AchR AB+ generalized myasthenia gravis (gMG):
- Does the patient have MGFA Clinical Classification of Class II to Class IV? _____   If yes, what is the Classification? _____
- Provide assessment of the baseline Quantitative Myasthenia Gravis (QMG) score.
- Does the patient have an MG-ADL total score of ≥6? _____   If yes, what is the score? _____
- Has the patient failed treatment over at least 1 year with at least 2 immunosuppressive therapies, or has failed at least 1 immunosuppressive therapy and required chronic plasmapheresis or plasma exchange (PE) or intravenous immunoglobulin (IVIG)? _____

■ **Ultomiris (ravulizumab) Medication Order**   **Patient's height in ft/in: _____   Patient's weight in lbs: _____**

☐ Loading dose, _____mg.
    ☐ If the patient is transitioning from eculizumab, loading dose is administered 2 weeks after last eculizumab, which was given on date _____.
☐ Maintenance dose, _____mg every ____ weeks for 1 year, starting 2 weeks after the loading dose.
Administer over one hours in adults. Follow manufacturer's instructions.

■ **Rescue Management in case of Reaction**
These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.
- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Ordering Provider Authorization**

Provider's Signature: _____   Name: _____   Date: _____

Address: _____

Phone: _____   Fax: _____   NPI #: _____   License: _____

Best Contact Person in Office: _____   Direct Phone Line to Contact Person: _____

STANDARD DOCUMENTATION TO INCLUDE:

Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides). Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results. If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.