TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

ULTOMIRIS ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Ultomiris

☐ Initiation:
Infuse Ultomiris _____ mg IV per protocol on day 1.

☐ Maintenance:
Infuse Ultomiris _____ mg IV per protocol starting two weeks after the initiation dose and continuing every 8 weeks.

☐ Maintenance:
Infuse Ultomiris _____ mg IV per protocol every 8 weeks.

Refills for one year from date of signature unless indicated below.

_____ Refills

Please include the following vaccine dates required for infusion. Primary vaccine series should be completed two weeks prior to start of therapy. Continued monitoring of booster vaccine administration and scheduling will be the responsibility of the prescriber:

Vaccine Administration Dates:

	Dose 1	Dose 2	Dose 3
MenACWY	_____	_____	_____
MenB	_____	_____	_____

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: _____325mg _____500mg _____650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: _____25mg _____50mg
- ☐ Famotidine: _____20mg _____40mg
- ☐ Ibuprofen: _____ 200mg _____400mg_____600mg
- ☐ Ondansetron: _____4mg _____ 8mg
- ☐ Other: _____

IV

- ☐ Dexamethasone: _____4mg _____8mg
- ☐ Diphenhydramine: _____25mg_____50mg
- ☐ Famotidine: _____20mg_____40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: _____4mg _____8mg
- ☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

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

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date