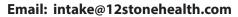
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





ULTOMIRIS ORDER FORM							
Date: ICD-10 Code:					Therapy Status		
Patient Name:		Allergies:			☐ New Start		
Date of Birth: Weight:		Weight: Ihs	lbs OR ka		☐ Continuing Therapy: Last Dose:		
PROVIDER INFORMATION							
Ordering Pr		Provide	er Fax:				
Provider NPI:			Provide	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		ınless W.	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:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other:				IV □ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg □ Other:			
LAB ORDERS (please indicate any labs to be drawn and frequency)				OTHER REQUIRED DOCUMENTATION			
Surveillance lab ordering and monitoring is the responsibility of the prescriber By signing below, I certify that the above therapy is med By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as m to payors with respect to this patient and prescription order. This enrollment Dispense as Written:				ically necessary. Prescriber's Signature (SIGN BELOW) y designated agent in submitting prior authorizations and other clinically required information			
Prescriber Name Date			Prescriber Name		 Date		