

**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: _____	<b>Therapy Status</b>
Patient Name: _____	Allergies: _____	<input type="checkbox"/> New Start
Date of Birth: _____	Weight: _____ lbs OR _____ kg	<input type="checkbox"/> Continuing Therapy: Last Dose: _____

**PROVIDER INFORMATION**

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

**MEDICATION ORDER**

<b>Ultomiris</b>	<input type="checkbox"/> Initiation: Infuse Ultomiris _____ mg IV per protocol on day 1.  <input type="checkbox"/> Maintenance: Infuse Ultomiris _____ mg IV per protocol starting two weeks after the initiation dose and continuing every 8 weeks.  <input type="checkbox"/> Maintenance: Infuse Ultomiris _____ mg IV per protocol every 8 weeks.	Refills for one year from date of signature unless indicated below.  _____ Refills	<p><i>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:</i></p> <p><b>Vaccine Administration Dates:</b></p> <table style="width:100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Dose 1</td> <td style="text-align: center;">Dose 2</td> <td style="text-align: center;">Dose 3</td> </tr> <tr> <td>MenACWY</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>MenB</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table>		Dose 1	Dose 2	Dose 3	MenACWY	_____	_____	_____	MenB	_____	_____	_____
	Dose 1	Dose 2	Dose 3												
MenACWY	_____	_____	_____												
MenB	_____	_____	_____												

**PRE-MEDICATIONS**

<p><b>Oral</b></p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p><b>IV</b></p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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**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**	(Please fax this signed order form, along with the following documents to 800-223-4063)  <ul style="list-style-type: none"> <li>• History &amp; Physical, Last Office Visit Note</li> <li>• Patient Demographics and Insurance Information</li> <li>• Medication List</li> <li>• Recent Lab Work</li> </ul>
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**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 Signature	Substitution Allowed: _____  _____ Prescriber Signature
Date	Date