CenterWell Specialty Pharmacy®

Soliris Ultomiris Prescription Request

E-prescribe: NCPDP ID number 3677955
Fax: 800-345-8534
Phone: 855-264-0104
Monday – Friday, 8 a.m. – 11 p.m., and
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Date: ________________________________

Patient information

Patient name: ____
Patient address: ____
____
Patient phone number: _________________________________
Member ID: ____________________________
Patient date of birth: _______________________
Allergies: ❑ No known allergies _____________________________
____

Current weight: ___________________❑ lbs ❑ kg

Primary diagnosis:
❑ Atypical hemolytic uremic syndrome (aHUS), D59.3
❑ Myasthenia gravis, G70.01
❑ Neuromyelitis optica spectrum disorder (NMOSD), G36.0
❑ Paroxysmal nocturnal hemoglobinuria (PNH), D59.5
❑ Other: _________________________________

Clinical documents (please attach):
History and physical and progress notes within past six months

Has the patient received complete or updated meningitis vaccinations?
❑ Yes ❑ No **Date of last vaccination:** ________________

Is the prescriber enrolled in the Soliris® REMS* program?
❑ Yes ❑ No

Is the prescriber enrolled in the Ultomiris® REMS program?
❑ Yes ❑ No

Venous access: ❑ Peripheral ❑ Port ❑ PICC
❑ Other: _________________
❑ Gravity as tolerated by patient ❑ Pump: ______________

Has prescriber initiated prior authorization? ❑ Yes ❑ No

First dose? ❑ Yes ❑ No

Expected date of first/next infusion: _______________

Site of care: ❑ Patient's home ❑ Physician's office
❑ Outpatient infusion clinic:
____

Prescriber signature: __________________________________

Date:_______________________

Prescriber name: ___________________________________
Prescriber address: _________________________________
____
DEA number: _______________________________
NPI number: _______________________________
Prescriber phone number: ___________________________
Prescriber fax number: ______________________________

Supervising prescriber information (if applicable):
Prescriber name: ___________________________________
Prescriber address: _________________________________
Prescriber phone number: ___________________________
DEA number: _______________________________________
NPI number: _______________________________________

Note: If all information is not completed, the patient request will not be processed. We will contact your office for clarification.

* REMS: Risk Evaluation and Mitigation Strategy

Prescription information

Directions: Please check appropriate box:

❑ **Soliris (eculizumab) 300 mg/30 mL**
❑ **Bkemv™ (eculizumab-aeeb) 300 mg/30 mL**
❑ **Epysqli® (eculizumab-aagh) 300 mg/30 mL**

❑ Myasthenia gravis, aHUS, NMOSD
900 mg IV weekly for the first four weeks, followed by 1,200 mg IV for the fifth dose one week later, then 1,200 mg IV every two weeks thereafter.

❑ PNH
600 mg IV weekly for the first four weeks, followed by 900 mg for the fifth dose one week later, then 900 mg every two weeks thereafter.

❑ **Ultomiris (ravulizumab-cwvz)**

❑ 300 mg/3 mL, 1,100 mg/11 mL

Infuse ________mg at week zero, then _______mg at week two and every eight weeks thereafter.

❑ **Other directions: ____**
____

Quantity: 28-day supply **Refill** for one year or __________

Pharmacy to dispense ancillary supplies as needed to establish IV and administer drug, including coordination of home health nursing unless otherwise noted. Please strike-through items that are not required:

normal saline 10 mL IV flush syringe
Directions: Use as directed to flush line with 10 mL before and after infusion and P.R.N. line care.
heparin 100 unit/mL 5 mL prefilled syringe (central line)
Directions: Use as directed to flush line with 5 mL after final saline flush.
sodium chloride 0.9% 250 mL
Directions: Use as directed to further dilute Soliris to 5 mg/mL.
sodium chloride 0.9% 50 mL or 100 mL
Directions: Use as directed to further dilute Ultomiris 300 mg/3 mL and 1,100 mg/ 11 mL to 50 mg/mL.

Premedications:
❑ *lidocaine/prilocaine cream 2.5%-2.5%* **Quantity:** 30 grams **Refill** x one year or ___
Directions: Apply topically to needle insertion site 30–60 minutes prior to needle insertion as directed.
Other: ____

Anaphylaxis kit maintained in the patient's home:
diphenhydramine 50 mg/mL injection **Quantity:** One vial **Refills**: 0
Directions: Use as directed via slow IV push as needed for anaphylaxis.
diphenhydramine 25 mg capsules **Quantity:** 10 capsules **Refills**: 0
Directions: Take 25–50 mg PO as needed for anaphylaxis.
epinephrine two-pack 0.3 mg or *epinephrine two-pack 0.15 mg (for patients weighing 15–30 kg)* **Quantity:** Two-pack **Refills**: 0
Directions: Use as directed IM as needed for anaphylaxis.

Skilled home infusion nursing visit to establish venous access, provide patient education related to therapy and disease state, administer medication as prescribed, and assess general status and response to therapy. The visit frequency is based on prescribed dosage orders.

You can send this prescription electronically by selecting "CenterWell Specialty Pharmacy" (National Council for Prescription Drug Programs [NCPDP] ID number 3677955) from the list of pharmacies on your e-prescribing tool.