



11162 Renner Blvd, Lenexa, KS 66219
 Fax Form To: 1-800-571-3995 Phone: 800-360-0520 ext. 103-6993
 Email Form To: Customer.ServiceFax@CVSHealth.com

Prescription Order / Nursing Order

PATIENT INFORMATION					
Needs by Date:		CVS Account #:			
First Name:	Last Name:	DOB:	Gender:		
Address:		City:	State:	ZIP:	
Phone:	If Minor, Parent/Caregiver/Guardian Name (Last, First):				
Alt. Phone:					
PRESCRIBER INFORMATION					
Prescriber Name:		Address:		City, State, ZIP:	
NPI:	DEA #:	Phone:	Fax:		
Contact Person:		Contact's Phone:			
DIAGNOSIS AND CLINICAL INFORMATION					
Primary Diagnosis:	<input type="checkbox"/> D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)		<input type="checkbox"/> D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)		
	<input type="checkbox"/> G36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD)		<input type="checkbox"/> G70.0 generalized Myasthenia Gravis (gMG)		
Height:	Weight:	Collection Date:			
Allergies:					
Patient is required to have a meningitis vaccine at least two weeks prior to starting therapy.			<input type="checkbox"/> Vaccinated	Date:	
			<input type="checkbox"/> Scheduled	Date:	
SERVICE LOCATION					
<input type="checkbox"/> Start of Treatment <input type="checkbox"/> Switch from Soliris to Ultomiris (First dose in a controlled setting is recommended)					
<input type="checkbox"/> Continuation of Therapy (Select maintenance dose location only)					
First Dose Location:		<input type="checkbox"/> Coram AIS (Drug, Diluents, Supplies, and Nursing for drug administration)			
		<input type="checkbox"/> MD Office <input type="checkbox"/> Other: (Drug Only for facility administration)			
Address:			Contact:		
City:		State:	ZIP:	Ph#:	
Maintenance Dose Location:		<input type="checkbox"/> Home Infusion <input type="checkbox"/> Coram AIS (Drug, Diluents, Supplies, and Nursing for drug administration)			
		<input type="checkbox"/> MD Office <input type="checkbox"/> Other: (Drug Only for facility administration)			
Address:			Contact:		
City:		State:	ZIP:	Ph#:	
SOLIRIS PRESCRIPTION INFORMATION					
Soliris 300mg Vial	<input type="checkbox"/> Loading Dose	mg / Dilute ml Soliris in equal volume Normal Saline and infuse intravenously once weekly for 4 weeks. Begin maintenance dose 1 week later. Adult: infuse over 35 minutes / Pediatric: infuse over hours		Quantity: 28-day supply	Refills:
	<input type="checkbox"/> Maintenance Dose	mg / Dilute ml Soliris in equal volume Normal Saline and infuse intravenously every 2 weeks. Adult: infuse over 35 minutes / Pediatric: infuse over hours		Quantity: 28-day supply	Refills:

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ULTOMIRIS PRESCRIPTION INFORMATION

Ultomiris	<input type="checkbox"/> 300mg/3ml Vial	Loading Dose: Dilute [checked dose from below chart] ml Ultomiris in equal volume Normal Saline and infuse intravenously on Day 1 over _____ hours (based on the maximum infusion rate in the chart below). Maintenance dose to follow 2 weeks later.	Quantity: 14-day supply	Refills:
	<input type="checkbox"/> 1100mg/11ml Vial		Quantity: 14-day supply	Refills:

Loading Dose Infusion Information (Check appropriate dose)

Body Weight Range (kg)	Loading Dose (mg)	Ultomiris Volume (ml)	Volume of NaCl Diluent	Total Volume (ml)	Minimum Infusion Time (hr)	Maximum Infusion Rate (ml/hr)
5 to <10	600	<input type="checkbox"/> 6	6	12	1.4	9
10 to <20	600	<input type="checkbox"/> 6	6	12	0.8	15
20 to <30	900	<input type="checkbox"/> 9	9	18	0.6	30
30 to <40	1,200	<input type="checkbox"/> 12	12	24	0.5	48
40 to <60	2,400	<input type="checkbox"/> 24	24	48	0.8	60
60 to < 100	2,700	<input type="checkbox"/> 27	27	54	0.6	90
≥ 100	3,000	<input type="checkbox"/> 30	30	60	0.4	150

Ultomiris	<input type="checkbox"/> 300mg/3ml Vial	Maintenance Dose: Dilute [checked dose from below chart] ml Ultomiris in equal volume Normal Saline and infuse intravenously over _____ hours (based on the maximum infusion rate in the chart below). Frequency of infusion: at week 2 then every 8 weeks thereafter.	Quantity: 56-day supply	Refills:
	<input type="checkbox"/> 1100mg/11ml Vial		Quantity: 56-day supply	Refills:

Maintenance Dose Infusion Information (Check appropriate dose)

Body Weight Range (kg)	Loading Dose (mg)	Ultomiris Volume (ml)	Volume of NaCl Diluent	Total Volume (ml)	Minimum Infusion Time (hr)	Maximum Infusion Rate (ml/hr)
5 to <10	300	<input type="checkbox"/> 3	3	6	0.8	8
10 to <20	600	<input type="checkbox"/> 6	6	12	0.8	15
20 to <30	2,100	<input type="checkbox"/> 21	21	42	1.3	33
30 to <40	2,700	<input type="checkbox"/> 27	27	54	1.1	50
40 to <60	3,000	<input type="checkbox"/> 30	30	60	0.9	67
60 to < 100	3,300	<input type="checkbox"/> 33	33	66	0.7	95
≥ 100	3,600	<input type="checkbox"/> 36	36	72	0.5	144

Complete below if Home Infusion or Coram AIS administration ONLY

<input type="checkbox"/> PIV (default if no selection)	
<input type="checkbox"/> Port	Port – Pump, NS 10mL & Heparin 100 units/ml 3-5ml
<input type="checkbox"/> PICC: # Lumens	PICC – NS 10ml & Heparin 100 units/ml 3-5ml + Maintenance flushes per lumen

*Give as PIV if Port/PICC failure

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PREMEDICATIONS (Home Infusion or Coram AIS administration ONLY)

<input type="checkbox"/> Medication:	Directions:	Quantity:	Refills to match prescription(s) above
<input type="checkbox"/> Medication:	Directions:	Quantity:	Refills to match prescription(s) above
<input type="checkbox"/> Medication:	Directions:	Quantity:	Refills to match prescription(s) above
<input type="checkbox"/> Medication:	Directions:	Quantity:	Refills to match prescription(s) above

Acute Infusion Reaction Medications (Home Infusion or Coram AIS ONLY)

<input type="checkbox"/> EpiPen 0.3 mg (adult)	Inject 0.3 mg IM/SQ as needed for allergic reaction. May repeat one time.	Quantity: 2	Refills:
<input type="checkbox"/> Epinephrine 0.3 mg (adult)	Inject 0.3 mg IM/SQ as needed for allergic reaction. May repeat one time.	Quantity: 2	Refills:
<input type="checkbox"/> EpiPen Junior 0.15mg (15-29 kg)	Inject 0.15 mg IM/SQ as needed for allergic reaction. May repeat one time.	Quantity: 2	Refills:
<input type="checkbox"/> Epinephrine Jr 0.15 mg (15-29 kg)	Inject 0.15 mg IM/SQ as needed for allergic reaction. May repeat one time.	Quantity: 2	Refills:

SUPPLIES

<input type="checkbox"/> Sodium Chloride 0.9% bag for dilution: 50ml, 100ml, 250ml (pharmacy to select required volume based on mixing requirements)	Dilute dose with equal amount of 0.9% sodium chloride for administration.	Quantity: QS	Refills: PRN
<input type="checkbox"/> Sodium Chloride 0.9% 10 ml (flush)	Use as directed per flushing protocol.	Quantity: QS	Refills: PRN
<input type="checkbox"/> Sterile Sodium Chl. 0.9% 10 ml (flush to access port)	Access port with 10 ml Sterile Normal Saline Flush.	Quantity: QS	Refills: PRN
<input type="checkbox"/> Heparin 100 units/ml, 5ml (flush to lock port)	Following infusion, flush port with 10ml Normal Saline, then 5 ml Heparin to lock.	Quantity: QS	Refills: PRN
<input type="checkbox"/> Heparin 10 units/ml, 5ml (flush to lock port)	Following infusion, flush port with 10ml Normal Saline, then 5 ml Heparin to lock.	Quantity: QS	Refills: PRN

Preparation and Administration

- Prior to administration, verify AIR medications are available at the site of infusion.
- Note that patients are at risk of an infusion reaction with each infusion. AIR medications are required for ALL mAB infusions.
- Validate patient's weight and review potential adverse reactions with patient.
- Do not begin preparation until IV access has been established and or patency confirmed.
- Venous Access - Peripheral unless otherwise specified in manufacturer information or patient has pre-existing central access.
- Diluent and preparation per manufacturer guidelines.
- Validate that oral pre-medications have been taken prior to mixing medication.
- Verify all injectable pre-medications are available and ready to administer prior to mixing medication.
- Infuse per manufacturer guidelines.
- All mABs administered intravenously shall be administered by a nurse.
- Refer to manufacturer guidelines for filtering and administration device information.
- Soliris must be diluted to a final admixture concentration of 5 mg/mL prior to administration.
- Ultomiris must be diluted to a final admixture concentration of 50 mg/mL prior to administration.
- Soliris/Ultomiris admixture should be administered by intravenous infusion. Do not administer as an intravenous push or bolus.
- Ultomiris utilizes a weight-based dosage regimen.
- Nurse shall monitor the patient for 1 hour after infusion is complete and perform a final set of VS at the end of that hour.

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Rx includes related diluents, pumps, DME, ancillary supplies (e.g., needles, syringes, dressings) as necessary for drug administration and nursing services for drug administration.

If HOME Infusion – all drugs and supplies including pump if needed is sent.

If CORAM AIS Infusion –No AIR medications are needed to be sent. Send all other supplies including any pre-meds to CORAM AIS. If pump is required for infusion - no pump is needed to be sent– only send 1) Pump sheet to nursing homecare to send with these orders

Additional Notes: _____

“Dispense As Written”/Brand Medically Necessary/Do Not Substitute/ No Substitution/ DAW/May Not Substitute Prescriber’s Signature: _____ Date: _____	May Substitute/Product Selection Permitted/ Substitution Permissible Prescriber’s Signature: _____ Date: _____
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words “No Substitution”: _____	
ATTN: New York and Iowa providers, please submit electronic prescription	

MD Agent/Title Issuing Order _____

Date & Time _____

RPh Name Receiving Verbal Order _____

Verify Read Back – Initials _____

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