BluHaven HEALTH

Ultomiris Referral Form

Fax: (984) 370-2352
Phone: (984) 370-2350
Email: connect@bluhaven.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | H & P | Patient Demographics | Most Recent Labs | Medication List | Tried and Failed Therapies

Is referring provider enrolled in FDA REMS program? ☐ Yes ☐ No | Vaccine administration details for all doses of meningococcal vaccine series

(Required for REMS program) ☐ Yes ☐ No Date: _____ | If not started, check here for infusion clinic to administer vaccine series ☐

Primary Diagnosis

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)
☐ D59.5 Paraxysmal Nocturnal Hemoglobinuria (PNH)
☐ G36.0 Neuromyelitis Optica
☐ Other: _____

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

☑ Per infusion clinic protocol: No recommended standard pre-meds for Ultomiris.

☐ Provider Prescribed: _____

Primary Medication Order

Weight 40kg-59kg:

☐ Ultomiris 2400mg IV at Week 0, then Ultomiris 3000mg IV at Week 2 and every 8 weeks thereafter

Weight 60kg-99kg:

☐ Ultomiris 2700mg IV at Week 0, then Ultomiris 3300mg IV at Week 2 and every 8 weeks thereafter

Weight ≥ 100kg:

☐ Ultomiris 3000mg IV at Week 0, then Ultomiris 3600mg IV at Week 2 and every 8 weeks thereafter

☐ Ultomiris _____ mg IV every _____ weeks

☐ Other: _____

First Dose: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: _____

Line Use/Care Orders

☑ Start PIV/ACCESS CVC ☑ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

☑ Administer acute infusion reaction and anaphylaxis medications per BluHaven Healths' protocol (see BluHaven.com for policy)

☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature *Date*