SPRINGSIDE INFUSION

Ultomiris

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis

☐ Myasthenia gravis (without acute exacerbation) (g70.00)
☐ Myasthenia gravis with acute exacerbation (g70.01)
☐ Paroxysmal nocturnal hemoglobinuria (pnh) (d59.5)
☐ Atypical hemolytic uremic syndrome (ahus) (d59.3)
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications

☐ N/A
☐ Provider prescribed: _____

Medication order

Dose

☐ Pt weight 40-59kg: 2,400 mg on week 0 and 2, then 3,00mg every 8 weeks
☐ Pt weight 60-99kg: 2,700 mg on week 0 and 2, then 3,000mg every 8 weeks
☐ Pt weight 100kg or more: 3,000 mg on week 0 and 2, then 3,600mg every 8 weeks
☐ 1200 mg (uc) - IV
☐ Other _____

Frequency

☐ Week 0, 2, then every 8 weeks
☐ Every 8 weeks
☐ Other _____

Medication route

☐ IV
☐ Other _____

Lab order (Include frequency)

Please list any labs to be drawn by the infusion clinic:
☐ N/A
☐ _____

Prerequisites

Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Proof of meningococcal vaccination at least 2 weeks prior to start of treatment

Please send to ☐ Columbia, MD ☐ Silver Spring, MD ☐ Bowie, MD ☐ Frederick, MD

Referring provider information

Referring provider name _____ **NPI** _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____