

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: Home Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Date of Birth: _____ Gender: _____
 Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA #: _____ NPI #: _____
 Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
 Secondary Insurance: _____ ID: _____ Group: _____
 Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

G70.0 Generalized Myasthenia Gravis (gMG)
 REMS Provider Enrollment Form Completed
 Documented meningococcal vaccine administration (at least 2 weeks prior to administration)
 Date Administered: _____
 Current Medication List: _____
 Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
 H&P
 Labs/Tests
 Patient Demographics, including insurance information
 Please attach original prescription orders
 Positive serologic test for anti-AChR antibody for gMG
 MG-ADL Score: _____
 MGFA classification: _____

MEDICAL HISTORY

Has patient previously received IVIG? Yes No
 Is patient currently undergoing TPE? Yes No
 Patient Weight: _____ kg lbs Height: _____ cm in
 Allergies: _____
 Line Access: Peripheral PICC Port
 Delivery Method: Infusion Pump Other: _____
 Therapy Start Date: _____ Therapy End Date: _____
 Nursing Coordination:
 Pharmacy to coordinate home health nursing visit as necessary: Yes No
 Home health nursing coordination not necessary. Reason:
 MD office to administer to patient
 Home health nursing already coordinated

PRESCRIPTION INFORMATION

Ultomiris® Prescription:	Quantity/Weeks Supply:	Refills:
<input type="checkbox"/> 40kg to <60kg: Loading Dose - 2400mg then 2 weeks later Maintenance Dose - 3000mg q 8 weeks		
<input type="checkbox"/> 60kg to <100kg: Loading Dose - 2700mg then 2 weeks later Maintenance Dose - 3300mg q 8 weeks		
<input type="checkbox"/> >100kg: Loading Dose - 3000mg then 2 weeks later Maintenance Dose - 3600mg q 8 weeks		
<input type="checkbox"/> Other: _____		

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
 NaCl 0.9% 5mL Heparin 10 units per mL
 NaCl 0.9% 10mL Heparin 100 units per mL Other: _____

Premedications & Other Medications
 Infusion supplies as per protocol Acetaminophen _____ mg PO prior to infusion
 Anaphylaxis Kit orders as per protocol Diphenhydramine _____ mg PO

ADDITIONAL COMMENTS:

Prescriber Signature: _____ Date: _____