InfuCare Rx®

Ultomiris® for gMG
Enrollment Form

✂ 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:
40kg to <60kg: Loading Dose - 2400mg then 2 weeks later **Maintenance Dose** - 3000mg q 8 weeks		
60kg to <100kg: Loading Dose - 2700mg then 2 weeks later **Maintenance Dose** - 3300mg q 8 weeks		
>100kg: Loading Dose - 3000mg then 2 weeks later **Maintenance Dose** - 3600mg q 8 weeks		
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: _____

✂