

## Ultomiris® for gMG **Enrollment Form**

Fax Referral To: 877-828-3941 Phone: 877-828-3940

City, State, Zip: City, State, Zip: Phone: Phone: Phone: Date of Birth: Gender: DEA #: NPI #:	Date Required:	Ship To: Home	Office	Other:		
Primary Insurance:  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) D36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD)  REMS Provider Enrollment Form Completed Documented meningococcal vaccine administration (at least 2 weeks prior to administration) Date Administration) Date Administration Date Administration Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached H&P Labs/Tests Positive serologic test for anti-AChR antibody for gMG MG-ADL Score:  MGFA classification:  PRESCRIPTION INFORMATION Ultomiris® Prescription:  PRESCRIPTION INFORMATION Ultomiris® Prescription:  PRESCRIPTION INFORMATION Ultomiris® Prescription:  PREMEDICATION ORDERS/OTHER MEDICATIONS Flush Protocol NaCl 0.9% 5ml. NaCl 0.9%	PATIENT INFORMATION  Patient Name:  Address:  City, State, Zip:  Home Phone:  Cell Phone:  Date of Birth:  Emergency Contact:  Phone:		PRESCRIBER INFORMATION  Prescriber Name:			
Prescription Card:   ID:   BIN:   PCN:   PCN:   PCN:   PCN:   PCD:   PCD	Primary Insurance:		ID:		Group:	
DIAGNOSIS  G70.0 Generalized Myasthenia Gravis (gMG) D36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD)  REMS Provider Enrollment Form Completed Documented meningococcal vaccine administration (at least 2 weeks prior to administration) Date Administerate: 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-ADI, Score: MGFA classification:  PRESCRIPTION INFORMATION  Ultomiris® Prescription:  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 - 3000mg q 8 weeks Other:  PREMEDICATION ORDERS/OTHER MEDICATIONS  Flush Protocol NaCl 0.9% 5ml. Heparin 10 units per mL NaCl 0.9% 5ml. Heparin 10 units per mL Inusion supplies as per protocol Acetaminophen mg PO prior to infusion	Secondary Insurance:		ID:		Group:	
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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	Illtomiria® Procarintian.	PRESCRIPTION	INFORMATI	ION	Quantity/Wooks Supplys	Pofille.
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		Acetaminor	ohen r	ng PO prior to infusio	on	
					<del>*</del>	
ADDITIONAL COMMENTS:						

Prescriber Signature:

Date: