TEXASINFUSION

1935 W. State Street STE 103
Garland, TX 75042
Ph: 972-372-7987
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ULTOMIRIS INFUSION REFERRAL FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Patient Weight = _____kg / _____lbs

DIAGNOSIS AND ICD 10 CODE			
☐ aHUS	ICD 10 Code: _____	☐ gMG classification II	ICD 10 Code: _____
☐ PNH	ICD 10 Code: _____	☐ gMG classification III	ICD 10 Code: _____
☐ Other:_____	ICD 10 Code: _____	☐ gMG classification IV	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ aHUS: documented (-) for Shiga toxin E. Coli and TTP
☐ Patient demographics AND Insurance Card	☐ gMG: (+) anti-AChR AB; Mg-ADL score; EMG report
☐ Clinical/Progress notes	☐ PNH: GPI deficiency flow cytometry analysis
☐ Meningococcal vaccine of BOTH MenACWY and MenB	☐ MD enrolled in REMS program

List Tried & Failed Therapies, including duration of treatment:
1)
2)
3)

PA Guidance: Failed Empaveli (pegcetacoplan) therapy. No HIGH risk of thrombosis or organ damage secondary to chronic hemolysis or high LDH activity. Is the patient transfusion dependent?

LOADING DOSE	MAINTENANCE DOSE
☐ 40-59kg - 2400mg IV DAY 0 ☐ 60-99kg - 2700mg IV DAY 0 ☐ 100kg or > 3,000mg IV DAY 0	☐ 40-59kg - 3,000mg IV Day 14 then every 8 weeks ☐ 60-99kg - 3,300mg IV Day 14 then every 8 weeks ☐ 100kg or > - 3,600mg IV Day 14 then every 8 weeks ■ Normal saline Flushes 10ml as needed (max 10 per infusion) ☐ Premeds:_____
Infusion orders	■ Nurse to start/pause/remove PIV as needed OR access/deaccess PICC/PORT. ■ DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 1L 0.9% NS)	
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses	

PRESCRIBER INFORMATION		
Prescriber Name:		NPI #:
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492

UPDATED: 1-2-2023