

**LAWRENCE COUNTY**  
**Memorial  Hospital**  
**DEACONESS ILLINOIS PARTNER**

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
DIAGNOSIS AND ICDE 10 CODE		
<input type="checkbox"/> Myasthenia Gravis without (acute) exacerbation	ICD 10 Code: G70.00	
<input type="checkbox"/> Myasthenia Gravis with (acute) exacerbation	ICD 10 Code: G70.01 _____	
<input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5	
<input type="checkbox"/> Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code: G36.0	
<input type="checkbox"/> Hemolytic-uremic syndrome (aHUS)	ICD 10 Code: D59.3	
<input type="checkbox"/> Other: _____	ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number <input type="checkbox"/> Acetylcholine Receptor Antibody test results (if Myasthenia Gravis)	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and tests supporting primary diagnosis <input type="checkbox"/> Documentation of meningococcal vaccines Pt may be required to submit a pregnancy test prior to treatment	
List of tried and failed therapies, including duration of treatment: _____		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____		
Initial Dosing	<input type="checkbox"/> J1303 Ultomiris 2400mg IV (40kg to less than 60kg) <input type="checkbox"/> J1303 Ultomiris 2700mg IV (60kg to less than 100kg) <input type="checkbox"/> J1303 Ultomiris 3000mg IV (100kg or greater)	
Maintenance Dosing	<input type="checkbox"/> J1303 Ultomiris 3000mg (40kg to less than 60kg) IV every 8 weeks starting 2 weeks after initial load <input type="checkbox"/> J1303 Ultomiris 3300mg (60kg to less than 100kg) IV every 8 weeks starting 2 weeks after initial load <input type="checkbox"/> J1303 Ultomiris 3600mg (100kg or greater) IV every 8 weeks starting 2 weeks after initial load	
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses		
<i>Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first dose of ULTOMIRIS, unless the risks of delaying ULTOMIRIS therapy outweigh the risk of developing a meningococcal infection. Comply with the most current National Advisory Committee on Immunization (NACI) recommendations for meningococcal vaccination in patients with complement deficiencies.</i>		
PREMEDICATION/LABS		
<input type="checkbox"/> Acetaminophen _____ mg PO PRN <input type="checkbox"/> CBC <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Benadryl _____ mg PO or IV <input type="checkbox"/> CMP <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Methylprednisolone _____ slow IV push <input type="checkbox"/> Other: _____ Date: _____ <input type="checkbox"/> Other: _____		
ADDITIONAL ORDERS/INFORMATION		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	Time:

ALL INFORMATION CONTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD. CONTACT US WITH QUESTIONS AT 618-943-8515. FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

**INFUSION ORDERS – ULTOMIRIS (RAVULIZUMAB-CWVZ)**