Clinical Specialty Infusions, LLC

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SOLIRIS/ULTOMIRIS/VYVGART/OCREVUS ENROLLMENT FORM

Account manager: _____ **Contact info:** _____

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		Patient/Caregiver (if applicable):	
Address:	City:	State:	Zip:
Main phone:	Alternate phone:	Email:	Last 4 of SSN (required):
Date of birth:	☐ Male or ☐ Female	Height (required): ☐ cm or ☐ inches	Weight (required): ☐ lb or ☐ kg

CLINICAL INFORMATION

Primary ICD-10 code:	Is patient currently on therapy? ☐ Yes or ☐ No	Previous tried/failed therapies:
Allergies:	Current medications:	

Please include face sheet, copy of insurance cards (front and back), H&P, clinicals, and any available lab results.

PRESCRIPTION AND ORDERS

Medication	Dosing		Quantity	Refills
☐ **Soliris** (Adult gMG)	**Induction**: ☐ 900mg IV once weekly x 4 weeks, then 1200mg x 1 on week 5 ☐ Other: _____	**Maintenance**: ☐ 1200mg IV every 2 weeks after induction ☐ Other: _____	☐ 5 doses for induction ☐ 4-week supply for maintenance ☐ Other: _____	x1 year unless otherwise noted: ☐ _____ refills ☐ Other: x_____
☐ **Ultomiris** (Adult gMG)	**Induction**: ☐ 40kg to <60kg: 2400mg IV x 1 dose ☐ 60kg to <100 kg: 2700mg IV x 1 dose ☐ ≥100kg: 3000mg IV x 1 dose	**Maintenance**: ☐ 40kg to <60 kg: 3000mg IV every 8 weeks ☐ 60kg to <100 kg: 3300mg IV every 8 weeks ☐ ≥100kg: 3600mg IV every 8 weeks ☐ Other: _____	☐ 1 dose for induction ☐ 8-week supply for maintenance ☐ Other: _____	x1 year unless otherwise noted: ☐ _____ refills ☐ Other: x_____
☐ **Vyvgart** (Adult gMG)	**Initial cycle**: ☐ Weight <120kg: 10mg/kg IV once weekly x 4 weeks ☐ Weight ≥120kg: 1200mg IV once weekly x 4 weeks ☐ Other: _____	☐ Additional cycle(s) after 50 days or more to be ordered after patient assessment. ☐ _____ # of additional cycle(s) after 50 days or more ☐ Other: _____	☐ 4-week supply for initial cycle ☐ 4-week supply for additional cycle >50 days after initial cycle ☐ Other: _____	☐ No refills after initial cycle ☐ _____ refills for additional cycle ☐ Other: x_____
☐ **Ocrevus** (Adult MS)	**Premedication 30 minutes prior to Ocrevus**: ☐ Methylprednisolone 100mg IV push ☐ Diphenhydramine 25-50mg PO or IV push ☐ Acetaminophen 500mg PO **Induction**: ☐ 300mg IV at week 0 and week 2	**Maintenance**: ☐ 600mg IV every 6 months ☐ Other: _____	☐ 2 doses for induction ☐ 1 dose every 6 months for maintenance	x1 year unless otherwise noted: ☐ No refills ☐ Other: x_____

Orders:

☐ Clinical Pharmacist to dose and send orders for review/signature. **Labs**:

Flush Orders: Flush with sodium chloride 0.9% 5-10mL and Heparin 100 Units/mL 3-5mL if needed for catheter maintenance.
Supplies: Dispense ancillary supplies, including ambulatory infusion pump, as needed to provide home infusion therapy.

Pre-Treatment:
PRN:
☐ Acetaminophen 500mg PO: 500-1000mg, 15-30 min prior to infusion
☐ Diphenhydramine 25mg PO: 500-1000mg, 15-30 min prior to infusion
☐ Hydration: Sodium chloride 0.9% 100-500 mL IV over 30 min before each infusion, as needed

Adverse/Anaphylactic Reactions, per protocol:
- Epinephrine 1:1000, 1 mL x 2
- Diphenhydramine 25mg tab #2
- Sodium chloride 0.9% 1000 mL Bag #1
- Diphenhydramine 50mg/1mL vial #1

Nursing Orders for Home Infusion: MONITOR (IV only)
Observe: Vital signs prior to infusion. Blood pressure and pulse every 15 minutes for first hour, then every 30 minutes until stable infusion rate, then every hour.
Watch for: Signs of fluid overload, cardiovascular symptoms, allergic reactions, skin rash, fever, and moderate to severe headache.

PRN:
☐ Ondansetron 4mg slow IVP as pre-med for infusion induced nausea
☐ Toradol 15mg-30mg SIVP as pre-med for infusion induced headache or muscle pain
☐ Methylprednisolone 1 mg/kg (12.5-125mg) slow IVP as pre-med or PRN for infusion-related cutaneous reaction or headache
☐ Ondansetron 4-8mg PO as pre-med, then every _____ hours x _____ post-infusion
☐ Other:

PRESCRIPTION AND ORDERS

Physician name:	Practice site name:		
Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	

Office contact and special instructions:

Prescriber Authorization: I authorize the pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's signature: Date: