CSI CLINICAL SPECIALTY INFUSIONS

Phone: 833-569-1005 | Fax: 430-200-4889 | Online: deliver.myforcura.com

SOLIRIS / ULTOMIRIS / VYVGART / VYVGART HYTRULO ENROLLMENT FORM

Account manager: _____ Contact info: _____

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		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 ☐ No	Previous tried/failed therapies:	Allergies:

REQUIRED (Soliris, Ultomiris): Patient is up to date for meningococcal vaccinations (MenACWY & MenB)? ☐ Yes ☐ No ☐ Pending

REQUIRED (Soliris, Ultomiris): Patient has positive serologic test for anti-AChR antibodies? ☐ Yes ☐ No ☐ Pending

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:** ☐ 900 mg IV once weekly x 4 weeks, then 1200 mg x 1 on week 5 ☐ Other: _____	**Maintenance:** ☐ 1200 mg IV every 2 weeks after induction ☐ Other: _____	☐ 5 doses for induction ☐ 4-week supply for maintenance ☐ Other: _____	x1 year unless noted otherwise: ☐ _____ refills
☐ **Ultomiris®** (Adult gMG)	**Induction:** ☐ 40 kg to <60 kg: 2400 mg IV x 1 dose ☐ 60 kg to <100 kg: 2700 mg IV x 1 dose ☐ ≥100 kg: 3000 mg IV x 1 dose	**Maintenance: (starting 2 weeks after induction dose)** ☐ 40 kg to <60 kg: 3000 mg IV every 8 weeks ☐ 60 kg to <100 kg: 3300 mg IV every 8 weeks ☐ ≥100 kg: 3600 mg IV every 8 weeks ☐ Other: _____	☐ 1 dose for induction ☐ 8-week supply for maintenance ☐ Other: _____	x1 year unless noted otherwise: ☐ _____ refills
☐ **Vyvgart®** (Adult gMG)	**Initial Cycle:** ☐ Weight <120 kg: 10 mg/kg IV once weekly x 4 weeks ☐ Weight ≥120 kg: 1200 mg IV once weekly x 4 weeks ☐ Other: _____	**Maintenance:** ☐ 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: _____	x1 year unless noted otherwise: ☐ _____ refills (begin no sooner than 50 days of the FIRST day of the previous infusion cycle).
☐ **Vyvgart® Hytrulo** (Adult gMG) (Adult CIPD)	**Initial Cycle:** ☐ 1008 mg/11,200 units SUBQ once weekly x 4 weeks	**Maintenance:** ☐ Additional cycle(s) after 50 days or more to be ordered after patient assessment ☐ ____ # of additional cycle(s) after 50 days or more ☐ 1008 mg/11,200 units SUBQ once weekly	☐ 4-week supply for initial cycle ☐ 4-week supply for additional cycle >50 days after initial cycle ☐ Other: _____ ☐ 4-week supply	x1 year unless noted otherwise: ☐ _____ refills (begin no sooner than 50 days of the FIRST day of the previous infusion cycle).

Medication Specific Infusion and Administration:
Soliris® - Administer over 35 minutes.
Vyvgart IV® - Administer at a rate of 125 mL/hr.
Ultomiris® - Administer using weight based rate as below.
Vyvgart Hytrulo® - Administer SUBQ over 30-90 seconds.

Labs:

Flush Orders (Infusions ONLY): Flush with 0.9% sodium chloride 5-10 mL pre and post medication and as needed, max per dispense x 60 syringes (refill x1 year). ONLY if CVAD, add Heparin 100 units/mL 3-5 mL to flush after final saline flush to maintain line patency as needed, max per dispense x 30 syringes (refill x1 year).
Supplies: Dispense ancillary supplies, including ambulatory infusion pump (IV infusions ONLY), as needed to provide home infusion therapy.

Premedication 30 minutes prior to infusion:
- ☐ Acetaminophen 500-1000 mg PO, dispense x1 bottle (refill x1 year)
- ☐ Diphenhydramine 25-50 mg PO, dispense x1 bottle (refill x1 year)

Adverse/Anaphylactic Reactions, per protocol (Subcutaneous):
- Epinephrine autoinjector 0.3 mg IM as directed PRN for anaphylaxis, dispense 2pk x 1 (refill x 1 year)

Adverse/Anaphylactic Reactions, per protocol (Intravenous): dispense ana-kit x 1 (refill x 1 year)
- Epinephrine 1:1000, 1 mL vial x 1
- Diphenhydramine 50 mg/1 mL vial x1
- Diphenhydramine 50 mg tab/cap x1
- 0.9% Sodium Chloride 500 mL bag x1

PRN: ☐ Ondansetron 4-8 mg slow IV push once as pre-med for nausea, then every _____ hours x _____ post-infusion (IV infusions ONLY), dispense x 2 doses (refill x1 year)
☐ Ondansetron 4-8 mg PO once as pre-med for nausea, then every _____ hours x _____ (SUBQ ONLY), dispense x 2 doses (refill x1 year)

Nursing Orders for Home Infusion: Provide skilled nursing for home medication administration as prescribed and per CSI nursing policies. Insert, access, and manage vascular access devices. Deliver nursing care for therapy duration and educate patient on medication, disease state, adverse reactions, and administration. Monitor patient response and report adverse events.

☐ Other:

PRESCRIBER INFORMATION

Prescriber 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:**