



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION

Primary ICD-10 Code (Please Specify Diagnosis): _____

Secondary ICD-10 Code (Please Specify Diagnosis): _____

MG-ADL* score (if known): _____ Has the patient received Meningitis vaccination? Yes No Date of vaccination: _____

Please check this box if the patient has declined vaccination Reason: _____

Adverse reactions with previous Ultomiris treatments? No Yes *If yes, Reason/Date:* _____

Please check to confirm: The patient is enrolled in the ULTOMIRIS REMS program; The patient has been counseled about the risks of meningococcal infection; The patient has received information and a Patient Safety Card about the symptoms and risks of meningococcal infection.

ULTOMIRIS® ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Strength	Dose/Frequency	Refills
Intravenous Ultomiris® (ravulizumab)	<input type="checkbox"/> 1,100mg/11mL vial <input type="checkbox"/> 300mg/3mL vial <input type="checkbox"/> 300mg/30mL vial <input type="checkbox"/> Other: _____	<input type="checkbox"/> Loading dose: Begin _____ mg IV on day 1 Then 2 weeks later <input type="checkbox"/> Maintenance dose: Begin _____ mg IV every _____ weeks <input type="checkbox"/> Other: _____	_____
Subcutaneous Ultomiris® (ravulizumab)	<input type="checkbox"/> 245mg/3.5 mL prefilled cartridge with on body injector	<input type="checkbox"/> 490 mg once weekly in adult patients greater than or equal to 40 kg body weight with PNH or aHUS. <input type="checkbox"/> Other: _____	_____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.