

PATIENT DEMOGRAPHICS:				
PATIENT NAME:	PATIENT'S CONTACT #:			
DATE OF REFERRAL:	ADDRESS:			
DATE OF BIRTH:	CITY, STATE, ZIP:			
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:				
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE MALE			
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST NKDA			
PRIMARY DIAGNOSIS:				
D59.5 - Paroxysmal nocturnal hemoglobinuria	D59.3 - Hemolytic-uremic syndrome			
G70.00 - Myasthenia gravis without (acute) exacerbation	G70.01 - Myasthenia gravis with (acute) exacerbation			
Other				
REQUIRED DOCUMENTATION: <u>Please provide a copy of the following documents.</u>				
<input checked="" type="checkbox"/> 1. INSURANCE CARD (Front & Back) <input checked="" type="checkbox"/> 2. PATIENT DEMOGRAPHICS <input checked="" type="checkbox"/> 3. MOST RECENT LABS <input checked="" type="checkbox"/> 4. MEDICATION LIST <input checked="" type="checkbox"/> 5. H & P <input checked="" type="checkbox"/> 6. TRIED/FAILED THERAPIES <input checked="" type="checkbox"/> 7. DOCUMENTED MENINGOCOCCAL VACCINE				
<input checked="" type="checkbox"/> Has patient previously been on Soliris (eculizumab)? (Provide documentation) Has there been a 2 week period from last dosing? Y N				
PRIMARY MEDICATION ORDER:				
<p><u>Ultomiris</u></p> <p>30 kg to less than 40 kg: Ultomiris 1200 mg IV loading dose at week 0, followed by 2700 mg IV at week 2, and every 8 weeks thereafter.</p> <p>40 kg to less than 60 kg: Ultomiris 2400 mg IV loading dose at week 0, followed by 3000 mg IV at week 2, and every 8 weeks thereafter.</p> <p>60 kg to less than 100 kg: Ultomiris 2700 mg IV loading dose at week 0, followed by 3300 mg IV at week 2, and every 8 weeks thereafter.</p> <p>100 kg or greater: Ultomiris 3000 mg IV loading dose at week 0, followed by 3600 mg IV at week 2, and every 8 weeks thereafter.</p> <p>Other: _____</p> <p>FIRST DOSE: Y N</p> <p><input checked="" type="checkbox"/> Refill x12 months unless otherwise noted.</p>	<th colspan="3">PRN & PREMEDICATIONS:</th>	PRN & PREMEDICATIONS:		
MEDICATIONS	30 minutes prior to every infusion	PRN		
Acetaminophen 650 mg PO		PRN every ____ hour for mild or moderate infusion reaction.		
Diphenhydramine 25 mg PO		PRN every ____ hour for mild or moderate infusion reaction.		
Diphenhydramine 25 mg IV		PRN every ____ hour for mild or moderate infusion reaction.		
Methylprednisolone 125 mg IV		PRN every ____ hour for mild or moderate infusion reaction.		
Other: _____		PRN every ____ hour for mild or moderate infusion reaction.		
LINE USE/CARE ORDERS:				
<input checked="" type="checkbox"/> START PIV/ACCESS CVC <input checked="" type="checkbox"/> FLUSH DEVICE PER FLOURISH HEALTH GROUP'S POLICY & PROCEDURE (SEE REVERSE SIDE) OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)	<th colspan="2">ADVERSE REACTION & ANAPHYLAXIS ORDERS:</th>	ADVERSE REACTION & ANAPHYLAXIS ORDERS:		
<input checked="" type="checkbox"/> ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLOURISH HEALTH GROUP'S POLICY AND PROCEDURE (SEE REVERSE SIDE) OTHER: (please fax other reaction orders if checking this box)				
PRESCRIBER INFORMATION: <u>Please check preferred form of communication.</u>				
PROVIDER NAME:	PHONE:			
OFFICE CONTACT:	FAX:			
ADDRESS:	EMAIL:			
CITY, STATE, ZIP:	NPI:			
_____ → (GENERIC SUBSTITUTION PERMITTED) PROVIDER SIGNATURE: _____ DATE: _____				
_____ → (DISPENSE AS WRITTEN) PROVIDER SIGNATURE: _____ DATE: _____				

FLOURISH HEALTH'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of Flourish Health Group's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	<ul style="list-style-type: none"> • Flushing • Dizziness • Headache • Apprehension • Diaphoresis • Palpitations • Nausea / Vomiting • Pruritis 	<ul style="list-style-type: none"> • Chest Tightness • Shortness of Breath • Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) • Increased Temperature (>2 Degrees Fahrenheit) • Urticaria 	<ul style="list-style-type: none"> • Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). • Increase Temperature (>2 Degrees Fahrenheit) with Rigors • Shortness of Breath with Wheezing • Laryngeal Edema • Chest Pain • Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% naCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLOURISH HEALTH UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		<i>0.9% Sodium Chloride</i>		<i>10 Units/mL</i>	<i>100 Units/mL</i>
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

FOR CHILDREN <33 LBS, FLOURISH HEALTH UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.