PNH Referral Form (IV Therapies)

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

PNH24-01

PATIENT INFORMATION

Last Name	First Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Work Phone	Cell Phone

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes*

Patient New to Therapy ☐ Naïve / New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date ____ /____ / ____
Height ________ in Weight ________ lb Date ____ /____ / ____	Allergies ☐ NKDA ☐ Drug Allergies (please list)
Therapies Tried and Failed (please list name and dose)	
Concomitant Medications (please list name and dose)	
ICD-10 Code ☐ D59.5 Paroxysmal nocturnal hemoglobinuria ☐ Other ___________________________________	

PRESCRIPTION – *please check all boxes across row*

Medication	Dose/Strength	Directions		Quantity	Refill
☐ **Soliris® (eculizumab)**	300 mg/30 mL (10 mg/mL) solution in a single-dose vial	Inject 600 mg via 35-minute intravenous infusion every 7 days for the first 4 weeks, followed by 900 mg for the fifth dose 7 days later, then 900 mg every 14 days thereafter		☐ 2 vials ☐ 3 vials ☐ 6 vials ☐ 8 vials	☐ 1-year ☐ ___________
☐ **Ultomiris® (ravulizumab)**	Intravenous ☐ 300 mg/30 mL (10mg/mL) solution in a single-dose vial ☐ 300 mg/3mL (100mg/mL) solution in a single-dose vial ☐ 1,100 mg/11mL (100 mg/mL) solution in a single-dose vial	**Loading Dose** ☐ 600 mg ☐ 900 mg ☐ 1,200 mg ☐ 2,400 mg ☐ 2,700 mg ☐ 3,000 mg	**Maintenance Dose** ☐ 300 mg every 4 weeks ☐ 600 mg every 4 weeks ☐ 2,100 mg every 8 weeks ☐ 2,700 mg every 8 weeks ☐ 3,000 mg every 8 weeks ☐ 3,300 mg every 8 weeks ☐ 3,600 mg every 8 weeks	☐ ____ vials	☐ 1-year ☐ ___________

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: ________________________________ ☐ MD ☐ DO ☐ PA. ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic	Date Shipment Needed By: ____ /____ / ____

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