PNH Referral Form (SC and Oral Therapies)

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

Zeal Specialty Pharmacy

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
☐ **Ultomiris® (ravulizumab)**	Subcutaneous ☐ 245 mg/3.5mL (70 mg/mL) solution in a single-dose prefilled cartridge	Subcutaneous **Not currently on Ultomiris or Soliris treatment** ☐ Inject 490 mg SUBQ 2 weeks after Ultomiris IV loading dose **Currently treated with Soliris** ☐ Inject 490 mg SUBQ 2 weeks after Ultomiris IV loading dose **Currently treated with Ultomiris IV administration** ☐ Inject 490 mg SUBQ 8 weeks after last Ultomiris IV dose **Maintenance** ☐ Inject 490 mg SUBQ once weekly	Subcutaneous ☐ 2 syringes ☐ 4 syringes ☐ 8 syringes	☐ 1-year ☐ _____
☐ **Fabhalta® (iptacopan)**	200 mg capsule	Take 200 mg orally twice daily with or without food	☐ 60 tablets ☐ 120 tablets ☐ 180 tablets	
☐ **Empaveli® (pegcetacoplan)**	1,080 mg/20 mL (54 mg/mL) solution in a single-dose vial	Inject 1,080 mg by subcutaneous infusion twice weekly via a commercially available pump	☐ 2 vials ☐ 4 vials ☐ 6 vials ☐ 8 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: ____ /____ / ____