Ultomiris

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

◯ Labs ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

◯ Patient has received both of the required meningitis vaccines (MenACWY and MenB). Date(s) of vaccinations:

Note: All patients are required to receive meningitis vaccinations at least 2 weeks prior to initiating Ultomiris unless initiation of Ultomiris is urgent.Please supply the vaccination records

ICD-10 CODE

◯ D59.5 Paroxysmal nocturnal hemoglobinuria (PNH) ◯ D59.3 Hemolytic-uremic syndrome ◯ G70.00 Myasthenia Gravis

◯ Other: ______________________________

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

Diphenhydramine (Benadryl) ◯ 25mg ◯ 50mg ◯ PO ◯ IV

Cetirizine (Zyrtec) ◯ 10mg PO

Methylprednisolone (Solu-Medrol) ◯ 40mg IV ◯ 125mg IV

Loratadine (Claritin) ◯ 10mg PO

Hydrocortisone (Solu-Cortef) ◯ 100mg IV

Other: ____________________ Dose:__________ Route:__________ Frequency: __________

MEDICATION ORDER

Ultomiris (ravulizumab-cwvz)

Dose:
Loading Dose: (this is a one time dose followed by maintenance dosing)

◯ 600mg IV ◯ 2,400mg IV
◯ 900mg IV ◯ 2,700mg IV
◯ 1,200mg IV ◯ 3,000mg IV

Maintenance Dose:

◯ 300mg IV ◯ 2,700mg IV ◯ 3,600mg IV
◯ 600mg IV ◯ 3,000 mg IV ◯ Other: __________
◯ 2,100mg IV ◯ 3,300 mg IV

Frequency: *(for maintenance dosing starting 2 weeks after loading dose)*

◯ every 4 weeks
◯ every 8 weeks
◯ Other: ______________

Meningococcal vaccination

◯ Health Infusion will administer a Meningococcal Conjugate (MenACWY) Vaccine and a Serogroup B Meningococcal (MenB) Vaccine series. **If not checked,** then please submit documentation with meningococcal vaccination information.

◯ Urgent administration is needed and antibiotic prophylaxis was prescribed.

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

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Provider Name **Provider Signature** **Date** ◯ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.