

RAVULIZUMAB (ULTOMIRIS®) PRESCRIBER ORDER FORM

FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128

NEW PATIENT OR

CHANGE ORDER:

Drug Change

Dose Change

Interval Change

Patient Name:

Date of Birth:

Phone:

Gender:

Address:

Allergies:

Height: in cm

Weight: lbs kg

CLINICAL INFORMATION

Primary Diagnosis Description:

ICD-10 Code:

Meningococcal Vaccination Status: Primary vaccination series completed – Date: _____
 MenACWY booster completed – Date: _____
 MenB booster completed – Date: _____

PRESCRIPTION

Ravulizumab (Ultomiris®) refill as directed x1 year

Loading Dose: Infuse 2400mg IV x 1 dose (patient weight 40 to 59 kg)
 Infuse 2700mg IV x 1 dose (patient weight 60 to 99 kg)
 Infuse 3000mg IV x 1 dose (patient weight ≥ 100 kg)
 Other: _____

Maintenance Dose: Infuse 3000mg IV every 8 weeks starting 2 weeks after loading dose (patient weight 40 to 59 kg)
 Infuse 3300mg IV every 8 weeks starting 2 weeks after loading dose (patient weight 60 to 99 kg)
 Infuse 3600mg IV every 8 weeks starting 2 weeks after loading dose (patient weight ≥ 100 kg)
 Other: _____

Infusion rate determined by patient weight in accordance with manufacturer guidelines.

Flush IV tubing with 0.9% Sodium Chloride 20 mLs after each infusion.

ANCILLARY ORDERS

Pre-Medication Orders

Acetaminophen 650mg PO 30 minutes before infusion. *Patient may use own supply, or patient may decline.*
 Diphenhydramine 25mg PO 30 minutes before infusion. *Patient may use own supply, or patient may decline.*
 Cetirizine 10mg IV 30 minutes before infusion.
 Other: _____

Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature:

Date:

PRESCRIBER INFORMATION

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State, Zip:

Office Contact:

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