Virginia Oncology Associates
MSIC
Multispecialty Infusion Clinic

(757) 271-0969 call
(757) 466-1128 fax

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:**	