

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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