Local Infusion

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ULTOMIRIS (RAVULIZUMAB-CWVZ) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

- ❑ Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00
- ❑ Myasthenia Gravis with acute exacerbation, ICD 10: G70.01
- ❑ Paroxysmal Nocturnal Hemoglobinuria (PNH), ICD 10: D59.5
- ❑ Atypical Hemolytic Uremic Syndrome (aHUS), ICD 10: D59.3
- ❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

- ❑ Acetaminophen (Tylenol) 500 mg PO
- ❑ Benadryl 25mg PO
- ❑ Famotidine 20 mg IV
- ❑ Cetirizine (Zyrtec) 10 mg PO
- ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Ultomiris	❑ Pt weight 40-59kg: 2,400 mg on week 0 and 2, then 3,000 mg every 8 weeks ❑ Pt weight 60-99kg: 2,700 mg on Week 0 and 2, then 3,300mg every 8 weeks ❑ Pt weight 100 kg or greater: 3,000mg on Week 0 and 2, then 3,600mg every 8 weeks	❑ IV	❑ Week 0, 2 then every 8 weeks ❑ Every 8 weeks

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ NH: 603.217.5371 ❑ ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: _____