aleracare
advanced infusion centers™

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Ultomiris (ravulizumab-cwvz)

Provider Order Form rev. 8/22/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

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

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

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

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

◯ Other: _____

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: _____

Documentation Required (Note: Send all labs, must include specific labs listed here)

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

◯ Patient has received both of the required meningitis vaccines (MenACWY-CRM 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.

Pre-Medication Order

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

cetirizine (Zyrtec) ◯ 10mg PO

loratadine (Claritin) ◯ 10mg PO

diphenhydramine (Benadryl) ◯ 25mg ◯ 50mg / ◯ PO ◯ IV

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

hydrocortisone (Solu-Cortef) ◯ 100mg IV

Other: _____

Dose:_____ Route:_____ Frequency: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

_____ _____ _____

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯