Ultomiris
(ravulizumab)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Myasthenia gravis without (acute) exacerbation (G70.00)
☐ Myasthenia gravis with (acute) exacerbation (G70.01)
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) (D59.5)
☐ Atypical Hemolytic Uremic Syndrome (aHUS) (D59.3)
☐ Neuromyelitis Optica Spectrum Disorder (NMOSD) (G36.0)
☐ Other: _____

PRESCRIPTION

Has the patient completed the full meningococcal vaccination series? ☐ Yes ☐ No

If no, the patient will receive first dose of Ultomiris at least 2 weeks after the first dose of the vaccine series. If you want to hold Ultomiris treatment until the patient has completed the full vaccine series, check here ☐

Prophylactic antibiotic coverage is recommended if starting Ultomiris prior to completion of the vaccine series. This is at the discretion of, and managed by, the referring provider.

Dosing

☐ Weight 40kg-59kg: Ultomiris 2400mg IV at week 0, then Ultomiris 3000mg IV at week 2 and every 8 weeks thereafter
☐ Weight 60kg-99kg: Ultomiris 2700mg IV at week 0, then Ultomiris 3300mg IV at week 2 and every 8 weeks thereafter
☐ Weight ≥ 100kg: Ultomiris 3000mg IV at week 0, then Ultomiris 3600mg IV at week 2 and every 8 weeks thereafter
☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Tried/Failed Therapies
- Most recent labs
- Medication List
- Is referring provider enrolled in the FDA REMS program? ☐ Yes ☐ No

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
- Epinephrine (weight-based dosing) PRN per protocol
- Diphenhydramine PRN per protocol
- 0.9% Sodium Chloride bolus PRN per protocol

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended pre-medications for this infusion.
☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

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