

RAVULIZUMAB (ULTOMIRIS™) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



Patient Name:		Date of Birth:		
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
Meningococcal Vaccination Status:	<input type="checkbox"/> Primary vaccination series completed – date: _____ <input type="checkbox"/> MenACWY booster completed – date: _____ <input type="checkbox"/> MenB booster completed – date: _____

Ravulizumab (Ultomiris™) Prescription

Ravulizumab (Ultomiris™) refill as directed x 1 year

Loading Dose: Infuse 2400 mg IV x 1 dose (patient weight 40 to 59 kg)
 Infuse 2700 mg IV x 1 dose (patient weight 60 to 99 kg)
 Infuse 3000 mg IV x 1 dose (patient weight ≥ 100 kg)

Other: _____

Maintenance Dose: Infuse 3000 mg IV every 8 weeks starting 2 weeks after loading dose (patient weight 40 to 59 kg)
 Infuse 3300 mg IV every 8 weeks starting 2 weeks after loading dose (patient weight 60 to 99 kg)
 Infuse 3600 mg 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.

Ancillary Orders

Anaphylaxis Kit
If this is a 1st dose, would you like Option Care to provide an anaphylaxis kit with the 1st dose?
 Yes – please complete Anaphylaxis Physician Order (FR-PC-036) No

Medication Orders

Acetaminophen 650 mg PO 30 min before infusion. Patient may use own supply or patient may decline.
 Diphenhydramine 25 mg PO 30 min before infusion. Patient may use own supply or patient may decline.

Other: _____

IV Flush Orders

Peripheral: NS 2 to 3 mL pre-/post-use.
 Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

No labs ordered at this time.
 Other: _____

Skilled nurse to administer doses intravenously. 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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