RAVULIZUMAB (ULTOMIRIS™) PRESCRIBER ORDER FORM

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

YOUR INTELLIGENT HEALTH COMPANY. UBACARE	**Patient Name:**			**Date of Birth:**	
	Address:				
	Phone:	**Height:**	☐ inches ☐ 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: _____

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:**	

