

Ravulizumab (Ultomiris®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVe Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

<p>Patient Name: _____</p> <p>Patient Address: _____</p> <p>Patient Phone Number: _____</p> <p>Date of Birth: ____/____/____</p> <p>Weight: ____kg Height: ____cm</p> <p>Allergies: _____</p>	<p>Primary Insurance: _____</p> <p>Member ID: _____</p> <p>Secondary Insurance: _____</p> <p>Member ID: _____</p>
<p style="text-align: center;">Diagnosis</p> <p><input type="checkbox"/> Hemolytic uremic syndrome (AHUS) (D59.3)</p> <p><input type="checkbox"/> Paroxysmal nocturnal hemoglobinuria (PNH) (D59.5)</p> <p><input type="checkbox"/> Neuromyelitis optica (NMOSD) (G36.0)</p> <p><input type="checkbox"/> Myasthenia gravis without acute exacerbation (G70.00)</p> <p><input type="checkbox"/> Other Diagnosis Code (ICD-10): _____</p> <p><input type="checkbox"/> Other Indication: _____</p> <p>Target start date: _____</p>	<p style="text-align: center;">Labs</p> <p><input type="checkbox"/> No labs ordered at this time</p> <p><input type="checkbox"/> Other: _____</p>
<p>Note: Meningococcal documentation required for all diagnoses:</p> <p><input type="checkbox"/> Primary vaccination series completed – date: _____</p> <p><input type="checkbox"/> MenACWY booster completed – date: _____</p> <p><input type="checkbox"/> MenB booster completed – date: _____</p>	
<p>Ravulizumab (Ultomiris)</p> <p>Initial dosing with maintenance (new adult patients):</p> <p><input type="checkbox"/> 40kg to 59kg - 2,400mg IV, followed by 3,000mg IV 2 weeks later, then 3,000mg IV every 8 weeks</p> <p><input type="checkbox"/> 60kg to 99kg - 2,700mg IV, followed by 3,300mg IV 2 weeks later, then 3,300mg IV every 8 weeks</p> <p><input type="checkbox"/> 100kg or > - 3,000mg IV, followed by 3,600mg IV 2 weeks later, then 3,600mg IV every 8 weeks</p> <p><input type="checkbox"/> Other: _____</p> <p>Maintenance Dose:</p> <p><input type="checkbox"/> 40kg to 59kg - 3,000mg IV every 8 weeks</p> <p><input type="checkbox"/> 60kg to 99kg - 3,300mg IV every 8 weeks</p> <p><input type="checkbox"/> 100kg or greater - 3,600mg IV every 8 weeks</p> <p><input type="checkbox"/> Other: _____</p> <p>Note: Administer with a 0.2-0.22 micron filter. Observe patient for 60 minutes post completion of infusion.</p>	

Pre-Medications and Pre-Protocol (ordered at physician discretion)	<input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____	Hydration <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other _____ _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following
Flushing Protocol (pre and post medication)	<input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL as needed for line care	<input type="checkbox"/> Heparin _____ Units/mL _____ mL as needed for line care
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	<ul style="list-style-type: none"> • Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure 	
<div> <div> Provider Name: _____ </div> <div> Provider Signature: _____ </div> </div> <div> <div> Attending Physician Name: _____ </div> <div> Provider NPI: _____ </div> </div> <div> <div> Office Phone Number: _____ </div> <div> Office Fax Number: _____ </div> </div> <p>(If ordering provider is an advanced practice practitioner)</p> <p>Note: This order is valid for 12 months from date of physician signature.</p>		