Los Angeles, CA
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ThrIVewell INFUSION WEST

Office: 310-481-9944 Fax : 310-766-7001

MMI

Ravulizumab-cwvz (Ultomiris)
Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

MENINGITIS VACCINE-PATIENTS ARE REQUIRED TO RECEIVE FIRST DOSE OF BOTH THE CONJUGATE AND SEROGROUP B VACCINES PRIOR TO INITIATING ULTOMIRIS INFUSIONS.

Unless otherwise noted, vaccines will be given 2 weeks prior to starting Ultomiris. IVX will schedule the patient for vaccine visit followed by Ultomiris two weeks later. If urgent Ultomiris is indicated in an unvaccinated patient, IVX will administer meningococcal vaccine(s) as soon as possible including same day as Ultomiris. Additionally, provider must prescribe patients with 2 weeks of antibacterial drug prophylaxis.

☐ Check here if this is an urgent start.

IVX WILL ADMINISTER BOTH VACCINES AS OUTLINED BELOW .

Meningococcal conjugate (MenACWY) vaccine

(Patient will be given either Menactra or Menveo vaccine based on availability and will receive two doses separate by at least eight weeks. Menactra and Menveo are not interchangeable and patient will receive same product for all doses in a series.)

Serogroup B Meningococcal (MenB) vaccine

(Patient will be given Bexsero or Trumenba vaccine based on availability and will receive either the two-dose series Bexsero at least one month apart or three-dose series Trumenba at 0, 1-2, and 6 months. Bexsero and Trumenba are not interchangeable and patient will receive same product for all doses in a series.)

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl)☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____Frequency:_____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ Other: _____

THERAPY ADMINISTRATION

☑ **Ravulizumab-cwvz** (Ultomiris) in 0.9% sodium chloride, intravenous infusion
☐ **Indication PNH**
- ***Dose: Induction*** *(Choose one)* If patient has already completed induction dose, proceed to maintenance dose.
  ☐ 2,400mg (40kg-less than 60kg) ☐ 2,700mg (60kg-less than 20kg)
  ☐ 3,000mg (100kg or greater) ☐ Other_____
- ***Dose: Maintenance:*** *(Choose one)* Starting 2 weeks after the loading dose and every 8 weeks thereafter .
  ☐ 3,000mg (40kg-less than 60kg) ☐ 3,300mg (60kg-less than 100kg)
  ☐ 3,600mg (100kg or greater) ☐ Other_____

☐ Indication aHUS
- ***Dose: Induction*** *(Choose one)* If patient has already completed induction dose, proceed to maintenance dose.
  ☐ 600mg (5-less than 10kg) ☐ 600mg (10-less than 20kg)
  ☐ 900mg (20-less than 30kg) ☐ 1,200mg (30-less than 40kg)
  ☐ 2,400mg (40-less than 60kg) ☐ 2,700mg (60-less than 100kg)
  ☐ 3,000mg (100kg or greater) ☐ Other_____
- ***Dose: Maintenance*** *(Choose one)* Starting 2 weeks after loading dose and every 8 or 4 weeks based on body weight
  ☐ 300mg (5-less than 10kg) ☐ 600mg (10-less than 20kg) *4 weeks
  ☐ 2,100mg (20-less than 30kg) ☐ 2,700mg (30-less than 40kg) *8 weeks
  ☐ 3,000mg (40-less than 60kg)☐ 3,300mg (60-less than 100kg) *8weeks
  ☐ 3,600mg (100kg or greater)
- Infuse over 35 min. in adults & 1-4 hours in pediatric patients
  ☑ For all doses, dilute to a final concentration of 5mg/ml in an infusion bag using 0.9% sodium chloride
  ☑ Infuse through 0.2 or 0.22 micron filter

☐ Patient is required to stay for 30 min. observation post infusion
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero /☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)
Other Doses: ☐ Year ☐ Other _____

PRN MEDICATIONS

(GIVEN BASED ON PATIENT ASSESSMENT)

- ☑ acetaminophen (Tylenol) 650mg PO every 6 hours for **mild** pain or fever (alternate with ibuprofen)
- ☑ ibuprofen (Advil) 400mg PO every 4 hours for **mild** pain or fever (alternate with acetaminophen)
- ☑ ketorolac (Toradol) 30mg SIVP x 1 for **moderate to severe** pain/he adache (Do not give with elevated creatinine. If pain/headache not relieved 15-20 minutes after administration notify provider. Consider stopping infusion and transfer to an acute care setting.)
- ☑ diphenhydramine (Benadryl) 25-50mg PO every 4 hours for **mild** itching or hives
- ☑ hydroxyzine 50mg PO every 12 hours for **mild** itching or hives (consider if diphenhydramine already given)
- ☑ diphenhydramine 25-50mg SIVP, for **severe** itching, rash, or shortness of breath. May repeat 25-50mg SIVP x 1
- ☑ ondansetron (Zofran) 4mg SIVP every 4-6 hours for nausea/vomiting, may repeat 4mg SIVP x1 for a max dose of 8mg

HYPERTENSION MANAGEMENT

SBP > 30mmhg above baseline or SBP > or = 160

- ☑ clonidine 0.1mg PO x 1

SBP > 40mmhg above baseline or BP > or = 170/100 Notify provider and repeat VS q 5 minutes

- ☑ hydralazine 10mg SIVP over 2-3 minutes, may repeat dose x 1 in 20 minutes (Do not give if heart rate >100 BPM)

SPECIAL INSTRUCTIONS

INFUSION/MONITORING PARAMETERS

- ☑ **If any of the following below are present, stop infusion, monitor vital signs every 5 minutes and notify provider.**
- ☑ If blood pressure remains >40mmhg above baseline or ≥ 170/100 after administration of PRN medications.
- ☑ If chest pain, pressure or tightness that is not relieved with PRN medic ation administration.
- ☑ If heart rate < 50 or > 110 and patient symptomatic; dizziness, short ness of breath, chest pain, pressure or discomfort.
- ☑ If SPO2 < 92% with or without supplemental oxygen.
- ☑ Any sudden onset or change in neurological symptoms.

*Premedicate patients with high dose corticosteroids (1,000 mg methylprednisolone or equivalent) immediately prior to LEMTRADA infusion and for the first 3 days of each treatment course.

*Administer anti-viral prophylaxis for herpetic viral infections starting on the first day of each treatment course and continue for a minimum of two months following treatment with LEMTRADA or until the CD4+ lymphocyte count is at least 200 cells per microliter, whichever occurs later .

*Observe patients for infusion reactions during and for at least 2 hours after each LEMTRADA infusion.

*Conduct the following laboratory tests at baseline and at periodic intervals until 48 months after the last treatment course of LEMTRADA in order to monitor for early signs of potentially serious adverse effects:

- Complete blood count (CBC) with differential (prior to treatment initiation and at monthly intervals thereafter)
- Serum creatinine levels (prior to treatment initiation and at monthly intervals thereafter)
- Urinalysis with urine cell counts (prior to treatment initiation and at monthly intervals thereafter)
- A test of thyroid function, such as thyroid stimulating hormone (TSH) level (prior to treatment initiation and every 3 months thereafter)
- Serum transaminases (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) and total bilirubin levels (prior to treatment initiation and periodically thereafter)

**Providers choosing to refer patients for Lemtrada infusions must complete this order set. Outside order sets will not be accepted. Please direct any questions or comments regarding the use of this order set to Matt Munden, RN Director of Nursing or Andrew Lasher, MD Chief Medical Officer.*

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider Phone Fax