

Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830



(Ultomiris)

Ravulizumab-cwvz

Infusion orders

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:

DIAGNOSIS (and ICD 10 code)

- ☐ Myasthenia gravis without (acute) exacerbation ICD-10 Code: G70.00
- ☐ Myasthenia gravis with (acute) exacerbation ICD-10 Code: G70.01
- ☐ Other disorders of phosphorus metabolism ICD 10 Code: D59.5
Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive
ICD 10 Code: G36.0
- Hemolytic-uremic syndrome (aHUS) ICD 10 Code: D59.3

NOTE

List Tried & Failed Therapies, including duration of treatment:

- 1)
- 2)

Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first dose of ULTOMIRIS, unless the risks of delaying ULTOMIRIS therapy outweigh the risk of developing a meningococcal infection. Comply with the most current National Advisory Committee on Immunization (NACI) recommendations for meningococcal vaccination in patients with complement deficiencies.

Ravulizumab-cwvz (Ultomiris) ORDERS

Initial Dosing

- ☐ 2,400 mg IV (40k to less than 60kg)
- ☐ 2,700 mg IV (60k to less than 100 kg)
- ☐ 3,000 mg IV (100k or greater kg)

Maintenance Dosing

- ☐ 3,000 mg (40k to less than 60kg) IV every 8 weeks starting 2 weeks after initial load
- ☐ 3,300 mg (60k to less than 100 kg) IV every 8 weeks starting 2 weeks after initial load

Maintenance Dosing ONLY

- ☐ 3,000 mg (40k to less than 60kg) IV every 8 weeks
- ☐ 3,300 mg (60k to less than 100 kg) IV every 8 weeks
- ☐ 3,600 mg (100k or greater kg) IV every 8 weeks
- ☐ **ADJUST DOSE BASED ON WEIGHT (KG) AT NEXT INFUSION AFTER NOTIFYING DR? *******

Refills*: None ☐ X6 months ☐ X1 year ☐ Other: _____

*(if not indicated order will expire one year from date signed)

REQUIRED DOCUMENTATION:

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Clinical/ Progress notes supporting primary dx
- ☐ Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis)

Documentation of meningococcal vaccines

- ☐ WITH DATES OF ADMINISTRATION OF MEN B & MEN ACWY
- OR

- ☐ WITH DATES OF ADMINISTRATION OF MEN ABCWY
- OR

- ☐ IF NOT FULLY VACCINATED - ☐ PHROPHLATIC ANTIBX RX SENT ☐

☐ Is your patient enrolled in the Ultomiris-REMS program? ☐ YES ☐ No (if no, must be enrolled to start therapy)

☐ Is the ordering PROVIDER enrolled in the Ultomiris-REMS program? ☐ YES ☐ NO (if no, must be enrolled to start therapy) =

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____