

Boca Raton
9980 Central Park Blvd
Suite 202, N
Boca Raton, FL 33428



Office: 212-803-3339 Fax : 646-768-8600

(Ultomiris)

Ravulizumab-cwvz

Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> 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 _____