Borough Park 1428 36th Street Suite 107 Brooklyn, NY 11218

Sheepshead Bay 2546 East 17th Street Fl, 1 Brooklyn, NY 11235

Bronx 226 West 238t

Signature **X**

Provider___

Bronx, NY

Queens 64-05 Yellowstone Blvd CF104 Forest Hills, NY 11375

Long Island City 36-36 33rd Suite 311 Long Island City, NY 11106

Midtown 120 East 56 Street Suite 3D New York, NY 10022

FIDI 30 Broad Street Suite 401 New York, NY 10004

NYC Upper East Side 225 E 70th Street Suite 1E New York, NY 10021

Central Park West 115 Central Park West Suite 15 New York, NY 10023





Terrytown 555 Taxter Road 3rd Floor Elmsford, NY 10523

Port Jefferson 12 Medical Drive Suite B Port Jefferson Station, NY 11776

Staten Island 27 New Dorp Lane Staten Island, NY 10306

Date

Fax_

Southampton 625 Hampton Road Southampton, NY 11968

Riverhead 1228 E Main Street

Holbrook

233 Union Avenue Suite 207 Holbrook, NY 11741

Suite A Riverhead, NY 11901

Rockville Centre 165 North Village Avenue Suite 133 Rockville Center, NY 11570

Manhasset 333 East Shore Road Suite 201 Manhasset, NY 11030

5 Towns 141 Washington Avenue Cedarhurst, NY 11559

New Hyde Park 1991 Marcus Ave 10 NY, 11042

:	Gramercy	M
h Street	7 Gramercy Park West	
10463	Lower Level	Mission Medic
	New York, NY, 10003	

Ravulizumab-cwvz(Ultomiris)	75 Froehlich Farm Woodbury, NY 11797 Lake Suc 1 Infusion orders Date:	
	INFORMATION	
Name:	DOB: SEX: M F	
ICD-10 code (required):	ICD-10 description:	
□NKDA Allergies:	Weight lbs/kg:	
REFERRA	AL STATUS	
□New Referral □Referral Renewal □Medication/Order C	hange Benefits Verification Only Discontinuation Order	
PHYSICIA	N 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)	Ravulizumab-cwvz (Ultomiris) ORDERS	
□ Myasthenia gravis without (acute) exacerbation □ Myasthenia gravis with (acute) exacerbation □ Other disorders of phosphorus metabolism 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 Immuniza- tion (NACI) recommendations for meningococcal vaccination in patients with complement deficiencies.	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 □ 3,300 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☐ Is the ordering PROVIDER enrolleD in the Ultomiris-REMS program? ☐		

___ Phone_