

Vermont  
28 Park Ave  
Suite #1A  
Williston, VT 05495



(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 \_\_\_\_\_