

Lexington  
1792 Alysbeba Way  
Suite 205  
Lexington, KY 40509

Bowling Green  
727 U.S. 31 W Bypass  
Suite 102  
Bowling Green, KY 42101



# Ravulizumab-cwvz (Ultomiris) 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
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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 \_\_\_\_\_