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

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

Bronx 226 West 238th Bronx, NY 1

Signature X

Provider_

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

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

E 70th St Upper East Side 225 E 70th Street Suite 1E E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022 New York, NY 10021 FIDI 30 Broad Street Suite 401 New York, NY 10004

NYC

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





Tarrytown 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

Suite A Riverhead, NY 11901

Holbrook 233 Union Avenue Suite 207 Holbrook, NY 11741

333 East Shore Road Suite 201 Manhasset, NY 11030

Manhasset

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

> New Hyde Park 1991 Marcus Ave Suite 110 Lake Success, NY, 11042

Woodbury 7600 Jericho Tpke, ower Level, Suite C500 Woodbury NY 11797

Massapequa	Gramercy	M
97 Grand Avenue	7 Gramercy Park West	
Massapequa, NY 11758	Lower Level	Mission Medica
	New York, NY, 10003	
	97 Grand Avenue	97 Grand Avenue 7 Gramercy Park West Massapequa, NY 11758 Lower Level

PATIENT	INFORMATION	
Name:	DOB: SEX: M 🗆 F [
CD-10 code (required):	ICD-10 description:	
NKDA Allergies:	Weight lbs/kg:	
REFERRA	AL STATUS	
□New Referral □Referral Renewal □Medication/Order Cl	hange \square Benefits Verification Only \square Discontinuation C)rder
PHYSICIA	N INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:	
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone: Fax:	
Practice Address:	City: State: Zip Code:	
Myasthenia gravis without (acute) exacerbation	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 startin weeks after initial load □ 3,300 mg (60k to less than 100 kg) IV every 8 weeks start 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:	ting 2
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 SENTE Is your patient enrolled in the Ultomiris-REMS program? YES No	(if no, must be enrolled to start therapy)	ìravis)

_ Phone_