TN
100 Covey Drive
Suite 307
Franklin, TN 37067

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Ravulizumab-cwvz (Ultomiris) Infusion orders Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐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 _____