RAVULIZUMAB (ULTOMIRIS®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

option care health™

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
Meningococcal Vaccination Status:	☐ Primary vaccination series completed – date: _____ ☐ MenACWY booster completed – date: _____ ☐ MenB booster completed – date: _____

Ravulizumab (Ultomiris®) Prescription

Ravulizumab (Ultomiris®) refill as directed x 1 year

Loading Dose:
- ☐ Infuse 2400 mg IV x 1 dose (patient weight 40 to 59 kg)
- ☐ Infuse 2700 mg IV x 1 dose (patient weight 60 to 99 kg)
- ☐ Infuse 3000 mg IV x 1 dose (patient weight ≥ 100 kg)
- ☐ Other: _____

Maintenance Dose:
- ☐ Infuse 3000 mg IV every 8 weeks starting 2 weeks after loading dose (patient weight 40 to 59 kg)
- ☐ Infuse 3300 mg IV every 8 weeks starting 2 weeks after loading dose (patient weight 60 to 99 kg)
- ☐ Infuse 3600 mg IV every 8 weeks starting 2 weeks after loading dose (patient weight ≥ 100 kg)
- ☐ Other: _____

Infusion rate determined by patient weight in accordance with manufacturer guidelines.
Flush IV tubing with NS 20 mLs after each infusion.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?
☐ Yes – please complete Anaphylaxis Physician Order (FR-PC-036) ☐ No

Medication Orders

- ☐ Acetaminophen 650 mg PO 30 min before infusion. Patient may use own supply or patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion. Patient may use own supply or patient may decline.
- ☐ Other: _____

IV Flush Orders

- ☐ Peripheral: NS 2 to 3 mL pre-/post-use.
- ☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

- ☐ No labs ordered at this time.
- ☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State:	**Zip:**	**Office Contact:**

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