RAVULIZUMAB (ULTOMIRIS®) PRESCRIBER ORDER FORM

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 0.9% Sodium Chloride 20 mLs after each infusion.

Ancillary Orders

Anaphylaxis Kit

If this is a 1st infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?
☐ Yes ☐ No

Dosage:
- ☐ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- ☐ Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- ☐ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

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: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- ☐ Implanted Port: 0.9% Sodium Chloride 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:**

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

