RAVULIZUMAB (ULTOMIRIS®) PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

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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