

ULTOMIRIS

(ravulizumab)

FAX to +1 208.963.3245 or Email
to intake@infusionspecialists.org
To ensure processing of your order,
please complete all fields.



PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card • H&P • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies
- Is referring provider enrolled in the FDA REMS program? Y N
- Has the patient received the 1st dose of meningococcal vaccine series? Y N Date: _____
 - If not started, check here for infusion clinic to administer vaccine series:

PRIMARY DIAGNOSIS

- G70.00 Myasthenia gravis without (acute) exacerbation (gMG) D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)
- G70.01 Myasthenia gravis with (acute) exacerbation (gMG) Other: _____
- D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for Ultomiris
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Weight 40kg-59kg:
 - Ultomiris 2400mg IV at week 0, then Ultomiris 3000mg IV at week 2 and every 8 weeks thereafter
- Weight 60kg-99kg:
 - Ultomiris 2700mg IV at week 0, then Ultomiris 3300mg IV at week 2 and every 8 weeks thereafter
- Weight ≥ 100kg:
 - Ultomiris 3000mg IV at week 0, then Ultomiris 3600mg IV at week 2 and every 8 weeks thereafter
- Ultomiris _____mg IV every _____weeks
- Other: _____
- First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per Infusion Specialists' protocol (See infusionspecialists.org com for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialists.org for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date