

# RAVULIZUMAB (ULTOMIRIS®) PRESCRIBER ORDER FORM

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



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 1<sup>st</sup> infusion dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> dose?

- Yes  No

- Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ 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.
  - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

### 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: