SPECIALTY INFUSION CENTER
An Access Infusion Care Company

ULTOMIRIS (RAVULIZUMAB-CWVZ) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

☐ Myasthenia gravis (gMG) ICD-10 Code: _____

☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) ICD-10 Code: _____

☐ Neuromyelitis Optica Spectrum Disorder (NMOSD) ICD-10 Code: _____

☐ Atypical Hemolytic Uremic Syndrome (aHUS) ICD-10 Code: _____

☐ Diagnosis _____ ICD-10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ H&P and Clinical/Progress notes supporting primary diagnosis

☐ Antibody results (if applicable): Anti-AQP4 for NMOSD, AChR for gMG

☐ Documentation of meningococcal vaccines

Is your patient enrolled in the Ultomiris-REMS program? ☐ Yes ☐ No (must be enrolled to start therapy)

Is the ordering PROVIDER enrolled in the Ultomiris and Soliris REMS? ☐ Yes ☐ No (must be enrolled to start therapy)

List Tried & Failed Therapies, including duration of treatment:

1)

2)

MEDICATION ORDERS

Loading Dose

☐ Ultomiris _____ mg IV as a single dose

Maintenance Dose

☐ Ultomiris _____ mg IV every _____ weeks, starting 2 weeks after the loading dose

Infusion rate determined by patient weight in accordance with manufacturer guidelines.

Refills*: ☐ None ☐ X 6 months ☐ X 1 Year ☐ Other: _____

■ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

■ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

■ RN to flush and lock VAD/CVAD per company protocol

Other: _____

PREMEDICATION ORDERS

☐ Acetaminophen 650mg PO prior to infusion

☐ Diphenhydramine 25mg PO prior to infusion

☐ Other: _____

☐ Other: _____

EMERGENCY MEDICATIONS

■ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

REV: 6/2025

Gaylord, MI
Phone: (989) 619-6253
Fax: (855) 857-3834

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