

Ultomiris (Ravulizumab-cwvz)

Infusion Order Form – Page 1 of 1



Preferred Clinic Location

- ☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg 2, Suite 300, Austin, TX 78758
P: (855) 481-8375
F: (512) 233-2288

Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: _____ Patient Name: _____ DOB: _____
ICD-10 code (required): _____ ICD-10 description: _____
☐ NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____
Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Provider Information

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Patient has been immunized with meningococcal vaccines (for serogroups A, C, W, Y and B) at least 2 weeks before administering the first dose of Ultomiris
- Supporting clinical notes (H&P) to support primary diagnosis:
 - Patient has Paroxysmal Nocturnal Hemoglobinuria
 - Patient has atypical Hemolytic Uremic Syndrome

Orders

NURSING

- ☒ Nursing care per [Harbor Health Nursing Procedures](#) and [Harbor Health Adverse Reaction Management Protocol](#).

LABORATORY

- ☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

THERAPY

- ☒ **Ravulizumab-cwvz** (Ultomiris) in 0.9% sodium chloride, intravenous infusion

Indication (Choose one) ☐ PNH ☐ aHUS ☐ gMG

Induction dose is 1 time only then proceed to maintenance order.

- ☐ **Dose: Induction** (Choose one) If patient has already completed induction dose, proceed to maintenance dose.
☐ 2,400mg (40kg-less than 60kg)
☐ 2,700mg (60kg-less than 100kg)
☐ 3,000mg (100kg or greater)

- ☐ **Dose: Maintenance:** (Choose one) Starting 2 weeks after the loading dose and every 8 weeks thereafter.

- ☐ 3,000mg (40kg-less than 60kg)
☐ 3,300mg (60kg-less than 100kg)
☐ 3,600mg (100kg or greater)

Ultomiris will be infused at the rate determined by the manufacturer as based on the patient's weight and dose.

- ☒ For all doses, dilute to a final concentration of 5mg/ml in an infusion bag using 0.9% sodium chloride
☒ Infuse through 0.2 or 0.22 micron filter
☐ Patient is required to stay for 60 min. observation

Provider Name (Print): _____

Provider Signature: _____

Date: _____