Provider Order Form

ULTOMIRIS (RAVULIZUMAB-CWVZ)

Uptiv Health

PATIENT

Full Name: ______________________ DOB: ______________________

Mobile Phone: ______________________ Weight: __________ ☐ lbs ☐ kg

Allergies: ______________________ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: __________ Next Treatment Date: __________

DIAGNOSIS ICD-10 code (must be specified)

☐ Generalized Myasthenia Gravis (gMG) G70.0
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) D59.5
☐ Neuromyelitis Optica Spectrum Disorder G36.0
☐ Atypical Hemolytic Uremic Syndrome (aHUS) D59.3
☐ Other: ______________________

PROVIDER

Provider Name: ______________________ Provider NPI: ______________________

Practice Name: ______________________ Referral Coordinator Name: ______________________

Practice Address: ______________________

Phone: ______________ Fax: ______________ Email: ______________________

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO	☐ 500 mg	☐ 650 mg	☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV	☐ 25 mg	☐ 50 mg	
☐ Methylprednisolone (Solu-Medrol) IV	☐ 40 mg	☐ 125 mg	
☐ Cetrizine (Zyrtec) 10 mg PO			
☐ Other:			

THERAPY ADMINISTRATION

Medication	Body Weight	Loading Dose	Maintenance Dose
☐ Ultomiris (Ravulizumab-Cwvz), IV	☐ 40 kg to 59 kg	2400mg IV x 1 dose	3000mg IV every 8 weeks, starting 2 weeks after loading dose
	☐ 60 kg to 99 kg	2700mg IV x 1 dose	3300mg IV every 8 weeks, starting 2 weeks after loading dose
	☐ 100 kg or greater	3000mg IV x 1 dose	3600mg IV every 8 weeks, starting 2 weeks after loading dose

☒ Flush with 0.9% sodium chloride at infusion completion.
☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every __________
☐ CMP	☐ at each dose	☐ every __________
☐ CRP	☐ at each dose	☐ every __________
☐ Other ______________	☐ at each dose	☐ every __________

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Patient has had the meningococcal vaccines (both MenACWY and MenB) ☐ Prescriber is enrolled in Ultomiris REMS program

Provider Signature ______________________ Date ______________