Ravulizumab-cwvz (Ultomiris)

Provider Order Form rev. 10/03/2024

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Myasthenia Gravis (anti-acetylcholine receptor antibody positive): Neuromyelitis Optica (NMOSD):

Other: Description:

REQUIRED INFORMATION

MenACWY: Date of 1st dose: _____ Brand: _____
Date of 2nd dose: _____ Brand: _____
Meb B: Date of 1st dose: _____ Brand: _____
Date of 2nd dose: _____ Brand: _____
(Trumenba only) Date of 3rd dose: _____
Prophylactic antibiotics prescribed: ☐ Yes / ☐ No
Date patient started prophylactic antibiotics *(if applicable)*: _____
Provider REMS ID: _____

☐ **For gMG diagnosis**: Patient is anti-acetylcholine receptor antibody positive (provide documentation)

☐ **For NMSOD diagnosis:** Patient is anti-aquaporin-4 (AQP4) antibody positive (provide documentation)

☐ **For gMG diagnosis:** Meningococcal vaccine(s) given on _____ date. First Soliris dose may be given at least 2 weeks later unless otherwise specified.

THERAPY ADMINISTRATION & DOSING

Administer Ultomiris IV over 1 hour ***(Choose one)***:

☐ **Weight 40-60kg:** Loading: 2400mg (in 24ml NS) at week 0, followed by 3000mg (in 30ml NS) at week 2-

- Maintenance: 3000mg (in 30ml NS) every 8 weeks

☐ **Weight 60-100kg:** Loading: 2700mg (in 27ml NS) at week 0, followed by 3300mg (in 33ml NS) at week 2

- Maintenance: 3300mg (in 33ml NS) every 8 weeks

☐ **Weight 100kg or more:** Loading: 3000mg (in 30ml NS) at week 0, followed by 3600mg (in 36ml NS) at week 2

- Maintenance: 3600mg (in 36ml NS) every 8 weeks

☐ **Switching from Eculizumab:** Administer loading dose 2 weeks after last dose of eculizumab followed by maintenance dose every 8 weeks

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- abnormal vital signs or signs/symptoms of infection or Meningitis
- New or worsening headache or altered mental status

☑ Record vitals before infusion then every 30mins until patient discharges. If reactions occur, slow or stop infusion

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

☑ Monitor Patient for 60mins after every infusion

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, EMG results, MRI results

Required Labs: AChR antibody, MuSK antibodies, CRP, ESR

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.