MRN:_____

DOB:_____

ULTOMIRIS™ (ravulizumab) PLAN OF TREATMENT

NOTE: Patient ***may be ineligible*** to receive eculizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, presents with any symptoms of meningococcal infections, and/or surgery.

1. Patient Name:_____ Height (inches):_____ Weight (lbs):_____

2. Allergies: _____

3. Primary Diagnosis: □ **D59.5 Paroxysmal nocturnal hemoglobinuria**

□ **Other ICD-10 Code/Diagnosis description:**_____

4.* Pre-medications:** ***Administered 30 minutes prior to infusion as selected:

**Product information does not suggest any pre-medication prior to infusion*

Acetaminophen: □ 650 mg PO □ 500 mg PO □ 325 mg PO	Diphenhydramine: □ 25 mg PO, □ 50 mg PO, □ 25 mg IVP, □ 50 mg IVP or Fexofenadine □ 60mgs or □ 180mgs, □ Cetirizine 10 mg, □ Loratadine 10 mg, Other: _____

Orders: Ultomiris™ (ravulizumab) IV dosing as follows:

Body Weight Range (kg)	Loading Dose (mg)	Maintenance Dose (mg)
greater than or equal to 40 to less than 60	2,400	3,000
greater than or equal to 60 to less than 100	2,700	3,300
greater than or equal to 100	3,000	3,600

Ultomiris™ to be diluted in 0.9% Sodium Chloride for a final concentration of 5mg/ml and infused using a .22 micron filter at the protocol rate for dose and volume. Follow each infusion with a (1) one hour post infusion monitoring period after each infusion.

5. Frequency/dose: ☐ **Loading dose**

☐ **Maintenance dose at week 2 and every 8 weeks**

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

6. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

MRN:_____

DOB:_____

Guidelines for Prescribing ULTOMIRIS™ (ravulizumab)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

☐ **Ultomiris™**(ravulizumab) is restricted to credentialed prescribers enrolled in the **ULTOMIRIS™**(REMS) program. Available at 1-888-765-4747.

☐ Include signed and completed **Plan of Treatment**.

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Include supporting clinical MD notes that include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Any documentation that Thrombotic Thrombocytopenic Purpura (TTP) has been ruled out, Shiga toxin E. Coli related hemolytic uremic syndrome (STEC-HUS) has been ruled out, and/or other test/labs to support diagnosis.**

☐ Other as requested: _____

Pre-Screening:

☐ Documented meningococcal vaccine administration

☐ Has patient previously been on Soliris(eculizumab)? Has there been a 2 week period from last dosing?

☐ Baseline CBC, LDH, and flow cytometry labs

WARNING: SERIOUS MENINGOCOCCAL INFECTIONS Life-threatening meningococcal infections/sepsis have occurred in patients treated with Ultomiris. Meningococcal infection may become rapidly life-threatening or fatal if not recognized and treated early *[see Warnings and Precautions (5.1)]*. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients with complement deficiencies. Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first dose of Ultomiris, unless the risks of delaying Ultomiris therapy outweigh the risk of developing a meningococcal infection *[see Warnings and Precautions (5.1)* for additional guidance on the management of the risk of meningococcal infection].Vaccination reduces, but does not eliminate, the risk of meningococcal infections. Monitor patients for early signs of meningococcal infections and evaluate immediately if infection is suspected.

Ultomiris is available only through a restricted program under a Risk Evaluation and Mitigation Strategy REMS, prescribers must enroll in the program *[see Warnings and Precautions (5.1)]*. Enrollment in the Ultomiris REMS program and additional information are available by telephone: 1-844-259-6783 or at www.Ultomirisrems.com.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.