Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Ultomiris™ (ravulizumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			Address:		
Date of Birth:			City, State, Zip:		
Height in inches:	Weight: LB or KG		Gender:	Allergies:	☐ See list ☑ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	D59.5 - Paroxysmal nocturnal hemoglobinuria	☐	G70.01 - Myasthenia Gravis without acute exacerbation
☐	D59.3 - Hemolytic Uremic Syndrome	☐	G70.00 - Myasthenia Gravis without acute exacerbation
☐	_____ - Other:		

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Documentation of meningococcal vaccine 2 weeks prior to start of therapy *or*		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive ravulizumab 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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	☐	25mg	☐	50mg				
	Methylprednisolone	☐	40mg	☐	125mg	☐	Other:		
	Famotidine	☐	20mg	☐	40 mg				
	Other:	☐							

PO	Acetaminophen	☐	325mg	☐	500mg	☐	650mg	☐	1000mg
	Famotidine	☐	20mg	☐	40mg				
	Diphenhydramine	☐	25mg	☐	50mg				
	Fexofenadine	☐	60mg	☐	180mg				
	Cetirizine	☐	10mg						
	Loratadine	☐	10mg						
	Other:	☐							

MEDICATION:

☑ Ultomiris™ (ravulizumab) to be diluted in NS. Infused via IV per protocol.

DOSE:

☐ Dosage based on the following guidelines from the FDA package labeling.

Patient Body Weight	Initial Dose	Maintenance Dose/Interval	
40kg to less than 60kg	2400mg	3000mg	every 8 weeks
60kg to less than 100kg	2700mg	3300mg	
100kg or greater	3000mg	3600mg	

☐ Other:_____

FREQUENCY:

☐ Loading dose at week 0 followed by maintenance dose at week 2 and every 8 weeks thereafter

☐ Maintenance dosing every 8 weeks

☐ Other: _____

SPECIAL/LAB ORDERS

☐ _____

_____

Follow each infusion with a 1-hour post observation.

Ultomiris™ (ravulizumab) is restricted to credentialed prescribers enrolled in the Ultomiris (REMS) program.

☑ Refills x 12 months unlees noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	