

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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 with acute exacerbation
D59.30 - Hemolytic Uremic Syndrome	G70.00 - Myasthenia Gravis without acute exacerbation
- Other:	

REQUESTED DOCUMENTATION:

1 Insurance information	IF NO:	IF YES:
2 History & Physical/Tried and failed therapies	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3 Full medication list		NEXT INFUSION DATE:
4 REQUIRED: Documentation of meningococcal vaccine (MenACWY AND MenB) at least 2 weeks prior to start of therapy		IF ORDER CHANGE:
		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		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

MEDICATION:

Ultomiris™ (ravulizumab) dose to be diluted in NS for a final concentration of 50mg/ml. Infused via IV per protocol. Flush entire line with 25ml NS at the end of the infusion.

DOSE (INDUCTION/MAINTENANCE):

Dose per guidelines from the following 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	

FREQUENCY (INDUCTION/MAINTENANCE):

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

Maintenance dosing every 8 weeks

Other: _____

Follow each infusion with a 1-hour post observation.

SUPPLEMENTAL DOSING:

Within 4 hours of an IVIG cycle, dose 600mg Ultomiris™

Other Supplemental Dosing: _____

Administration: Ultomiris™ (ravulizumab) supplemental dose to be diluted in NS to a final concentration of 50mg/mL and infused via IV per protocol. **Prime line with 25mL of NS before supplemental dose.** Flush entire line with 25mL of NS at the end of the infusion.

SPECIAL/LAB ORDERS:

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

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

Start PIV/Access CVC

Flush device per facility standard flushing procedure

Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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



Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- 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.**

Palmetto Infusion 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com