

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

Rev 4.29.25

## PATIENT DEMOGRAPHICS:

Patient Name: \_\_\_\_\_

Patient's Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Height in inches: \_\_\_\_\_ Weight: \_\_\_\_\_ LB or \_\_\_\_\_ KG Gender: \_\_\_\_\_ Allergies: \_\_\_\_\_ See list  NKDA

## DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> 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	LAST INFUSION DATE:
3 Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4 <b>REQUIRED:</b> Documentation of meningococcal vaccine (MenACWY AND MenB) at least 2 weeks prior to start of therapy	FROM PREVIOUS THERAPY:	<b>IF ORDER CHANGE:</b>
		<b>Continue current order until insurance approved</b>

## 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
60kg to less than 100kg	2700mg	3300mg
100kg or greater	3000mg	3600mg

every 8 weeks

## SUPPLEMENTAL DOSING FOLLOWING IVIG CYCLE COMPLETION:

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

## 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: \_\_\_\_\_

## SPECIAL/LAB ORDERS:

\_\_\_\_\_

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

**Follow each infusion with a 1-hour post observation.**

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.

## 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
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