Referral Status:		MRN:
☐ New referral	☐ Order change	☐ 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 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
2	History & Physical/Tried and failed therapies
3	Full medication list
4	**REQUIRED:** Documentation of meningococcal vaccine (MenACWY AND MenB) at least 2 weeks prior to start of therapy

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

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				
	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) 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	

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: _____

Follow each infusion with a 1-hour post observation.

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.

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	

Palmetto INFUSION

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