



# Ravulizumab-cwvz (Ultomiris) Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

## Patient Demographics Information

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
Emergency Contact Name, Relationship		Emergency Contact Phone Number	

## Additional Documentation Needed

- Copy of insurance cards
- Patient face sheet w/demographics
- History and Physical
- CBC w/diff, BMP, & CMP
- Recent vitals including blood pressure
- Meningitis vaccine (REMS requirement)

## Patient Insurance Information

Insurance Plan #1		Insurance Plan #2	
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

## Patient Clinical Information

Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (inches)	Weight (lbs.)	Allergies (food/drug)
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## Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:	Current MG-ADL Score:
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## Medication Information / Prescription and Orders

<b>Medication:</b>  Ultomiris	<b>Directions:</b> Infuse IV per manufacturer guidelines. Titration rate according to package insert. Dilute Ultomiris dose in Sodium Chloride 0.9% as directed by vial size in package insert.	<b>Quantity/Refills</b> Dispense: 1 months supply, refill x12mo. Unless otherwise noted <input type="checkbox"/> Other
40-59 kg <input type="checkbox"/> Loading Dose: 2,400 mg IV as a single dose <input type="checkbox"/> Maintenance dose: 3,000 mg IV every 8 weeks, starting 2 weeks after the loading dose 60-99 kg <input type="checkbox"/> Loading Dose: 2,700 mg IV as a single dose <input type="checkbox"/> Maintenance dose: 3,300 mg IV every 8 weeks, starting 2 weeks after the loading dose ≥100 kg <input type="checkbox"/> Loading Dose: 3,000 mg IV as a single dose <input type="checkbox"/> Maintenance dose: 3,600 mg IV every 8 weeks, starting 2 weeks after the loading dose Supplemental Dose (with concurrent IVIg therapy) <input type="checkbox"/> 600 mg IV within 4 hours following completion of IVIg infusion, if Ultomiris maintenance dose not administered Other <input type="checkbox"/> _____ mg IV every _____ week(s), _____		<input type="checkbox"/> Other  <b>*If subsequent treatment cycles only</b> <b>Date of last infusion:</b>  <input type="checkbox"/> Loading Dose <input type="checkbox"/> Maintenance dose <input type="checkbox"/> Supplemental Dose  <b>Next dose due:</b>

## Line Access

RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications per Heritage Biologics policy. <input type="checkbox"/> Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium chloride 0.9% IV before and after medication administration or every 24 hours while IV access in place. <input type="checkbox"/> Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% IV as needed for port access. <input type="checkbox"/> Heparin Lock 100U/mL 5 mL Flush: Lock with 5 mL heparin 100U/mL after each use or daily while port accessed.	Dispense: Quantity #QS + PRN refills unless otherwise noted <input type="checkbox"/> Other
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## Adverse Reaction Orders

- Severe reaction (w/breathing problems): CALL 911, administer epinephrine 0.3 mg IM. #QS + PRN refills

## Prescriber Information

Physician Name		Office Contact	
Practice Address		Practice Phone	
NPI#	License #	DEA#	
Physician Signature Required - Substitution Permitted	Date	Physician Signature Required - Dispense as Written	Date