# Ravulizumab-cwvz (Ultomiris) Patient Referral Form

## 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 ☐M ☐F | Height (inches) | Weight (lbs.) | Allergies (food/drug) |
|---|---|---|---|
| | | | |

## Statement of Medical Necessity / Primary Diagnosis

ICD10: Description of diagnosis: Current MG-ADL Score:

## Medication Information / Prescription and Orders

**Medication:**

Ultomiris

**Directions:**

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.

40-59 kg
- ☐ Loading Dose: 2,400 mg IV as a single dose
- ☐ Maintenance dose: 3,000 mg IV every 8 weeks, starting 2 weeks after the loading dose

60-99 kg
- ☐ Loading Dose: 2,700 mg IV as a single dose
- ☐ Maintenance dose: 3,300 mg IV every 8 weeks, starting 2 weeks after the loading dose

≥100 kg
- ☐ Loading Dose: 3,000 mg IV as a single dose
- ☐ Maintenance dose: 3,600 mg IV every 8 weeks, starting 2 weeks after the loading dose

Supplemental Dose (with concurrent IVIg therapy)
- ☐ 600 mg IV within 4 hours following completion of IVIg infusion, if Ultomiris maintenance dose not administered

Other
- ☐ _____ mg IV every ____ week(s), _____

**Quantity/Refills**

Dispense:
1 months supply, refill x12mo. Unless otherwise noted
☐ Other

*If subsequent treatment cycles only
Date of last infusion:

☐ Loading Dose ☐ Maintenance dose
☐ Supplemental Dose

Next dose due:

## Line Access

RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications as ordered.

☐ Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium choride 0.9% IV before and after medication administration or every 24 hours while IV access in place.
☐ Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% IV as needed for port access.
☐ 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
☐ Other

## 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 |
|---|---|---|---|
| | | | |