

**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 | - History and Physical | - Recent vitals including blood pressure |
| - Patient face sheet w/demographics | - CBC w/diff, BMP, & CMP | - 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)
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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

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.	Quantity/Refills Dispense: 1 months supply, refill x12mo. Unless otherwise noted ☐ Other
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), _____		*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 per orders below. ☐ 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. ☐ 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.	Line Type: ☐ PIV ☐ Port/CVAD	Dispense: Quantity #QS + PRN refills unless otherwise noted ☐ 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