Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Ultomiris™ (ravulizumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:		
Patient Name:			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		**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	every 8 weeks
60kg to less than 100kg	2700mg	3300mg	
100kg or greater	3000mg	3600mg	

SUPPLEMENTAL DOSING:

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

☐ Other Supplemental Dosing: _____

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 unlees noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

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	