PREMIER INFUSION CENTER

📄 Ultomiris (ravulizumab-cwvz) IV Infusion Order Form

📞 405-442-7577 📠 405-442-7223
📧 orders@premierinfusioncenter.com

👤 Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continue **Last Treatment Date:** ____ / ____ / ____

🔹 Diagnosis (ICD-10 Selection)

☐ D59.5 – Paroxysmal nocturnal hemoglobinuria (PNH)
☐ D59.3 – Atypical hemolytic uremic syndrome (aHUS)
☐ G70.00 – Myasthenia gravis without acute exacerbation
☐ G70.01 – Myasthenia gravis with acute exacerbation
☐ Other: _____ **ICD-10 Code:** _____

🔹 Infusion Order

- **Induction Dose (based on weight):**
  ☐ 2400 mg IV (40– < 60 kg)
  ☐ 2700 mg IV (60–< 100 kg)
  ☐ 3000 mg IV (≥100 kg)
- **Maintenance Dose (starting 2 weeks after induction):**
  ☐ 3000 mg IV every 8 weeks (40–
  ☐ 3300 mg IV every 8 weeks (60–
  ☐ 3600 mg IV every 8 weeks (≥100 kg)
- ☐ Dilute to final concentration of 50 mg/mL in 0.9% sodium chloride
- ☐ Infuse over ≥35 minutes using 0.2–0.22 micron in-line filter
- ☐ Observation: 60 minutes post-infusion
- ☐ Refills: ☐ None ☐ 12 months ☐ Other: _____

◆ Meningococcal Vaccination

☐ Documentation of completed MenACWY and MenB series attached
☐ Provider acknowledges patient may begin Ultomiris prior to vaccine completion and assumes responsibility for antimicrobial prophylaxis
☐ REMS enrollment confirmed

◆ Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard infusion protocol

◆ Adverse Reaction & Anaphylaxis Orders

☐ Premier Infusion Center Protocol (premierinfusioncenter.com)
☐ Other – please fax preferred reaction orders to 405-442-7223

◆ Premedication (Recommended)

☐ Acetaminophen: ☐ 650 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Methylprednisolone: ☐ 125 mg ☐ IV
☐ Hydrocortisone: ☐ 100 mg ☐ IV
☐ Other: _____ **Dose:** _____ **Route:** _____

◆ Laboratory Monitoring

☐ CBC ☐ CMP ☐ LDH ☐ Creatinine/eGFR
☐ Anti-AChR antibody (for gMG) ☐ ADAMTS13 activity (for aHUS)
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Each infusion ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

◆ Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
☐ Meningococcal vaccine records ☐ REMS enrollment confirmation
☐ Documentation of prior therapies or intolerance

◆ Ordering Provider & Demographics

- **Name: _____**
- **NPI: _____ License #: _____**
- **Contact: _____ Phone: _____ Fax: _____**
- **Email: _____**
- **Signature: _____ Date: ____ / _____ / _____**