RED RIVER HEALTH
Ambulatory Infusion Clinic

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ULTOMIRIS (ravulizumab) Infusion Orders

Patient Name: DOB: ☐ M ☐ F

☐ NKDA Allergies:

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider: Provider NPI:

Practice Phone: Practice Fax:

Diagnosis *(please provide ICD-10 code)*:

☐ D59.5 – Paroxysmal nocturnal hemoglobinuria

☐ D59.3 – Hemolytic-uremic syndrome

☐ G70.00 – Myasthenia gravis w/o exacerbation

☐ G70.01 – Myasthenia gravis w/ exacerbation

Pre-Medication:

☐ Tylenol 1000mg PO

☐ Solu-Medrol 125mg IVP

☐ Cetirizine 10mg PO

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg PO

☐ Diphenhydramine 25mg IVP

☐ Other: _____

Required Documents:

☑ Patient Demographic Sheet

☑ Clinical/Progress Notes supporting primary diagnosis *(please attach)*

☑ Meningococcal vaccination (both conjugate & serogroup B) are required **prior** to initiating infusions (*please attach vaccine record*)

Has the patient previously been on SOLIRIS?
☐ Yes ☐ No Date of last dose? _____

ULTOMIRIS ORDERS:

Dosing: ☐ 30kg to <40kg: 1200mg IV loading dose, 2700mg maintenance dose

☐ 40kg to <60kg: 2400mg IV loading dose, 3000mg IV maintenance dose

☐ 60kg to <100kg: 2700mg IV loading dose, 3300mg IV maintenance dose

☐ 100kg or greater: 3000mg IV loading dose, 3600mg IV maintenance dose

Pt. weight: _____
(ensure unit of measure is noted)

Frequency: ☐ Initial loading dose, followed by maintenance dose at week 2, and every 8 weeks thereafter

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: Date: