Ravulizumab-cwvz (Ultomiris)

Provider Order Form rev. 07/30/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Myasthenia Gravis (anti-acetylcholine receptor antibody positive): Neuromyelitis Optica (NMOSD):

Other: Description:

REQUIRED INFORMATION

MenACWY: Date of 1st dose: _____ Brand: _____
Date of 2nd dose: _____ Brand: _____
Meb B: Date of 1st dose: _____ Brand: _____
Date of 2nd dose: _____ Brand: _____
(Trumenba only) Date of 3rd dose: _____
Prophylactic antibiotics prescribed: ☐ Yes / ☐ No
Date patient started prophylactic antibiotics *(if applicable)*: _____
Provider REMS ID: _____

☐ **For gMG diagnosis**: Patient is anti-acetylcholine receptor antibody positive (provide documentation)

☐ **For NMSOD diagnosis:** Patient is anti-aquaporin-4 (AQP4) antibody positive (provide documentation)

☐ **For gMG diagnosis:** Meningococcal vaccine(s) given on _____ date. First Soliris dose may be given at least 2 weeks later unless otherwise specified.

THERAPY ADMINISTRATION & DOSING

Administer Ultomiris IV over 1 hour ***(Choose one)***:

☐ **Weight 40-60kg:** Loading: 2400mg (in 24ml NS) at week 0, followed by 3000mg (in 30ml NS) at week 2-
- Maintenance: 3000mg (in 30ml NS) every 8 weeks

☐ **Weight 60-100kg:** Loading: 2700mg (in 27ml NS) at week 0, followed by 3300mg (in 33ml NS) at week 2
- Maintenance: 3300mg (in 33ml NS) every 8 weeks

☐ **Weight 100kg or more:** Loading: 3000mg (in 30ml NS) at week 0, followed by 3600mg (in 36ml NS) at week 2
- Maintenance: 3600mg (in 36ml NS) every 8 weeks

☐ **Switching from Eculizumab:** Administer loading dose 2 weeks after last dose of eculizumab followed by maintenance dose every 8 weeks

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:
- abnormal vital signs or signs/symptoms of infection or Meningitis
- New or worsening headache or altered mental status

☑ Record vitals before infusion then every 30mins until patient discharges. If reactions occur, slow or stop infusion

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

☑ Monitor Patient for 60mins after every infusion

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, EMG results, MRI results

Required Labs: AChR antibody, MuSK antibodies, CRP, ESR

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.