Ultomiris® IV

Provider Order Form Rev. 10/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Hemolytic-uremic syndrome (aHUS), D59.3

☐ Paroxysmal nocturnal hemoglobinuria (PNH), D59.5

☐ Other: _____, ICD10 _____

☐ Myasthenia gravis without (acute) exacerbation, G70.00

☐ Myasthenia gravis with (acute) exacerbation, G70.01

INFUSION ORDERS

MEDICATION

Ultomiris® (ravulizumab)

DOSE, DIRECTIONS, and DURATION

For aHUS and PNH:

Patient Weight: 5 to <10 kg
- ☐ Induction: Infuse 600 mg IV x 1 dose
- ☐ Maintenance: Infuse 300 mg IV every 4 weeks x 1 year

Patient Weight: 10 to <20 kg
- ☐ Induction: Infuse 600 mg IV x 1 dose
- ☐ Maintenance: Infuse 600 mg IV every 4 weeks x 1 year

Patient Weight: 20 to <30 kg
- ☐ Induction: Infuse 900 mg IV x 1 dose
- ☐ Maintenance: Infuse 2100 mg IV every 8 weeks x 1 year

Patient Weight: 30 to <40 kg
- ☐ Induction: Infuse 1200 mg IV x 1 dose
- ☐ Maintenance: Infuse 2700 mg IV every 8 weeks x 1 year

Patient Weight: 40 to <60 kg
- ☐ Induction: Infuse 2400 mg IV x 1 dose
- ☐ Maintenance: Infuse 3000 mg IV every 8 weeks x 1 year

Patient Weight: 60 to <100 kg
- ☐ Induction: Infuse 2700 mg IV x 1 dose
- ☐ Maintenance: Infuse 3300 mg IV every 8 weeks x 1 year

Patient Weight: ≥ 100 kg
- ☐ Induction: Infuse 3000 mg IV x 1 dose
- ☐ Maintenance: Infuse 3600 mg IV every 8 weeks x 1 year

For gMG:

Patient Weight: 40 to <60 kg
- ☐ Induction: Infuse 2400 mg IV x 1 dose
- ☐ Maintenance: Infuse 3000 mg IV every 8 weeks x 1 year

Patient Weight: 60 to <100 kg
- ☐ Induction: Infuse 2700 mg IV x 1 dose
- ☐ Maintenance: Infuse 3300 mg IV every 8 weeks x 1 year

Patient Weight: ≥ 100 kg
- ☐ Induction: Infuse 3000 mg IV x 1 dose
- ☐ Maintenance: Infuse 3600 mg IV every 8 weeks x 1 year

☐ Other Dose: _____

Initiate Maintenance Dose 2 weeks after Induction Dose

Administration:

- Using Ultomiris® 100 mg/ml vials: Infuse loading dose at maximum rate of 90 mL/hr and maintenance dose at maximum rate of 95 mL/hr Infusion for patients weighing 60 to <100 kg. Final diluted bag concentration = 50 mg/mL.
  Infusion rate for all other patient body weight or vial concentration will be determined in accordance with manufacturer guidelines.
- Administer infusions using an infusion set with a 0.2 to 0.22 micron in-line filter

☐ Observe patient for 1 hour following completion of each IV administration

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CMP q _____ ☐ CBC with diff/platelets q _____

☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

Patient Name: _____ DOB: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply.

☐ **REQUIRED:** Patient will have been immunized with a meningococcal vaccine at least 2 weeks prior to receiving the first dose of Ultomiris®.

☐ **REQUIRED:** Provider is enrolled in the Ultomiris® REMS program.

For aHUS only:

☐ Diagnosis of thrombocytopenic purpura (TTP) has been ruled out by ONE of the following:
- ☐ ADAMTS 13 activity level > 5%
- ☐ Patient has failed a trial of plasma exchange

☐ Absence of Shiga toxin-producing E. coli related infection is documented

For PNH only:

☐ Deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) documented by flow cytometry with ONE of the following:
- ☐ ≥ 5% PNH type III red cells
- ☐ ≥ 51% of GPI-anchored protein deficient polymorphonuclear cells

☐ Patient has required at least one transfusion -OR- has a documented history of a thromboembolic event

☐ Patient has documented LDL level at 1.5 times the upper limit of normal range

For generalized Myasthenia Gravis (gMG) only:

☐ Presence of anti-acetylcholine receptor (AchR) antibody has been confirmed

☐ Patient has a Myasthenia Gravis Foundation of America (MGFA) clinical classification of II, III, or IV at initiation of therapy

☐ Patient's baseline MG-Activities of Daily Living (ADL) total score is ≥ 6 ***(Attach copy of assessment)***

☐ Patient has objective evidence of unresolved symptoms of gMG, e.g., difficulty swallowing, difficulty breathing, or functional disability

LAB AND TEST RESULTS (required)

☐ LDL labwork (for PNH)

☐ Positive anti-AChR antibody lab (for gMG)

☐ Other: _____

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

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