LIFE
SPECIALTY SOLUTIONS

ULTOMIRIS
(ravulizumab)

PATIENT INFORMATION

PATIENT NAME: ______ PHONE #: ______

ADDRESS: ______ CITY, STATE, ZIP: ______

DATE OF BIRTH: ______ EMAIL: ______

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Med List 5. Most Recent Labs 6.Tried/Failed Therapies

7. Is referring provider enrolled in the FDA REMS program? ☐ Yes ☐ No

8. Has the patient received the 1st dose of meningococcal vaccine series? ☐ Yes ☐ No Date:______

If not started, check here for infusion clinic to administer vaccine series: ☐

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)
☐ D59.5 Paraxysmal Nocturnal Hemoglobinuria (PNH)
☐ Other ______

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ______

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Ultomiris
☐ Provider Prescribed: ______

PRIMARY MEDICATION ORDER

Weight 40kg-59kg:
☐ Ultomiris 2400mg IV at week 0, then Ultomiris 3000mg IV at week 2 and every 8 weeks thereafter

Weight 60kg-99kg:
☐ Ultomiris 2700mg IV at week 0, then Ultomiris 3300mg IV at week 2 and every 8 weeks thereafter

Weight ≥ 100kg:
☐ Ultomiris 3000mg IV at week 0, then Ultomiris 3600mg IV at week 2 and every 8 weeks thereafter

☐ Ultomiris ______mg IV every ______weeks
☐ Other ______

FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC
☑ Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: ______ PHONE: ______

OFFICE CONTACT: ______ FAX: ______

ADDRESS: ______ EMAIL: ______

CITY, STATE, ZIP: ______ NPI AND LICENSE: ______

✖ ______
PROVIDER SIGNATURE ______ DATE