Checklist for Ultomiris (ravulizumab) Referral

Patient Name: _____ **DOB:** _____ **Date:** _____

Referring Physician: _____ **NPI:** _____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ **Office Fax:** _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ☐ Patient demographic information
- ☐ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ☐ Supporting clinical notes and office visits. Two notes preferred.
  - Note should include any therapies tried/failed, and must include discussion about Ultomiris
  - Medication list and allergies
- ☐ Supporting lab reports/imaging for Ultomiris treatment
- ☐ Ultomiris Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible --

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Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterNE.com

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Prescribing Order: Ultomiris (ravulizumab)

Date of Order: _____

Patient Name: _____ **DOB:** _____ **M/F:** ____

Diagnosis (include ICD-10 code/s):_____

☐ **NKDA** **Allergies:** _____

Patient Weight: _____

Premedication:

☐ Acetaminophen 1000mg PO
☐ Loratadine 10mg or Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Diphenhydramine 25mg IV
☐ Solu-medrol 125mg IV
☐ Other: _____

Lab Orders:

☐ _____

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Ultomiris Medication Order

✓ Ultomiris IV dosing per table:

Body Weight	Loading Dose	Maintenance Dose
40 – 60kg	2400mg	3000mg
60 – 100kg	2700mg	3300mg
>100kg	3000mg	3600mg

✓ Dilute Ultomiris in 0.9% Sodium Chloride for a final concentration of 5mg/ml and infuse via 0.22 micron filter at appropriate rate per weight per manufacturer medication guidelines

Frequency: ☐ Loading Dose ☐ Maintenance at week 2 and every 8 weeks

Administration:

✓ Do not administer if patient has active signs or symptoms of infection.
✓ In case of infusion reaction, STOP infusion and follow NCNE infusion reaction protocol. Notify physician.

Ordering Provider Name **NPI**

Signature **Date**

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