Ravulizumab-cwvz (Ultomiris)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:	DOB:	
☐NKDA Allergies:	Weight (lbs / kg):	Height:	
Patient Status: ☐New to Therapy ☐Continuing Therapy - Last Treatment Date:		Next Due Date:	
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
DIAGNOSIS AND ICD 10 CODE			
☐Myasthenia gravis without (acute) exacerbation	ICD-10 Code: G70.00		
☐Myasthenia gravis with (acute) exacerbation	ICD-10 Code: G70.01		
☐Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5		
☐Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code: G36.0		
☐Hemolytic-uremic syndrome (aHUS)	ICD 10 Code: D59.3		
REQUIRED DOCUMENTATION/Testing			
☐This signed order form by the provider ☐ Patient demographics AND insurance info ☐Clinical/Progress notes supporting primary dx	☐Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis) ☐Documentation of meningococcal vaccines		
Is your patient enrolled in the Ultomiris-REMS program? ☐YES ☐N Is the ordering PROVIDER enrolled in the Ultomiris-REMS program? ☐YES ☐N (if no, must be enrolled to start therapy)			
List Tried & Failed Therapies (if Myasthenia Gravis) 1) 2)			
MEDICATION ORDER			
Initial Dosing	☐ 2,400 mg IV (40k to less than 60kg) ☐ 2,700 mg IV(60k to less than 100 kg) ☐ 3,000 mg IV (100k or greater kg)		
Maintenance Dosing	☐ 3,000 mg (40k to less than 60kg) IV every 8 weeks starting 2 weeks after initial load ☐ 3,300 mg (60k to less than 100 kg) IV every 8 weeks starting 2 weeks after initial load ☐ 3,600 mg (100k or greater kg) IV every 8 weeks starting 2 weeks after initial load		
Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____ **(if not indicated order will expire one year from date signed)*			

Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first dose of ULTOMIRIS, unless the risks of delaying ULTOMIRIS therapy outweigh the risk of developing a meningococcal infection. Comply with the most current National Advisory Committee on Immunization (NACI) recommendations for meningococcal vaccination in patients with complement deficiencies.

Provider Name (Print) **Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

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