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)	

VACCINATION DATE(s)		
MenACWY	**MenB**	**MenABCWY**
1st Dose Date: ____ /____ /____ ☐ Menveo ☐ Menactra ☐ MenQuadfi 2nd Dose Date: ____ /____ /____ ☐ Menveo ☐ Menactra ☐ MenQuadfi	1st Dose Date: ____ /____ /____ ☐ Bexsero ☐ Trumenba 2nd Dose Date: ____ /____ /____ ☐ Bexsero ☐ Trumenba	1st Dose Date: ____ /____ /____ ☐ Penbraya 2nd Dose Date: ____ /____ /____ ☐ Penbraya
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.		

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)

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

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

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)*	

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

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