Ravulizumab (Ultomiris®) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.

Fax completed form, insurance information and clinical documentation to 414-260-7368.

Name: ______________________ Date of Birth: ______________________

Address: ______________________

Phone: ______________ Height: __________ ☐ inches ☐ cm Weight: __________ ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: ______________________ ICD-10 Code(s): ______________

Meningococcal Vaccination Status:
- ☐ Primary vaccination series completed – date: ______________
- ☐ MenACWY booster completed – date: ______________
- ☐ MenB booster completed – date: ______________

Ravulizumab (Ultomiris®)Prescription

Ravulizumab (Ultomiris®) refill as directed x 1 year

Initial Dose:
- ☐ Infuse 2400 mg IV x 1 dose (patient weight 40 to 59 kg)
- ☐ Infuse 2700 mg IV x 1 dose (patient weight 60 to 99 kg)
- ☐ Infuse 3000 mg IV x 1 dose (patient weight ≥ 100 kg)
- ☐ Other: ______________

Maintenance Dose:
- ☐ Infuse 3000 mg IV every 8 weeks starting 2 weeks after loading dose (patient weight 40 to 59 kg)
- ☐ Infuse 3300 mg IV every 8 weeks starting 2 weeks after loading dose (patient weight 60 to 99 kg)
- ☐ Infuse 3600 mg IV every 8 weeks starting 2 weeks after loading dose (patient weight ≥ 100 kg)
- ☐ Other: ______________

Infusion rate determined by patient weight in accordance with manufacturer guidelines.
Flush IV tubing with NS 20 mLs after each infusion.

Ancillary Orders

Anaphylaxis Orders
- ☐ Treat per Froedtert Home and Specialty Infusion protocol.

Medication Orders
- ☐ Acetaminophen 650 mg PO 30 min before infusion. Patient may use own supply or patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion. Patient may use own supply or patient may decline.
- ☐ Other: ______________

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:
- ☐ Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.
- ☐ Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

Lab Orders
- ☐ No labs ordered at this time.
- ☐ Other: ______________

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

______________________ ______________ ______________
Prescriber Signature | Date | Time

______________________ ______________ ______________
Prescriber Name | Phone | Fax

______________________ ______________
Address | NPI

______________________ ______________
City, State, Zip | Office Contact

Froedtert Home and Specialty Infusion
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Menomonee Falls, WI 53051
262-532-5040