

Ravulizumab-cwvz (Ultomiris)

Provider Order Form rev. 8/23/26



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Mobile Phone Number: _____
Weight (lbs/kg): ☐ NKDA Allergies: _____
Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION (Please include the following with the order to support processing & insurance approval)

- Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)
- Is referring provider enrolled in FDA REMS program? ☐ Yes ☐ No

DIAGNOSIS ICD-10 CODE (Provider must specify)

- | | |
|--|---|
| ☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG) | ☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG) |
| ☐ G36.0 Neuromyelitis Optica Spectrum Disorder | ☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH) |
| ☐ D59.39 Other hemolytic-uremic syndrome | |
| ☐ Other: _____ | |

MENINGOCOCCAL VACCINATION

- Has the patient completed the full meningococcal vaccination series?
☐ Yes ☐ No
- If yes, Fax or attach documentation of administered vaccines
- If no, the patient will receive first dose of Ultomiris at least two weeks after the first dose of the vaccine series. If you want to hold Ultomiris treatment until the patient has completed the full vaccine series, check here ☐

PRIMARY MEDICATION ORDER

Ravulizumab-cwvz (Ultomiris) in 0.9% sodium chloride, intravenous infusion

- **Ultomiris will be infused at the rate determined by the manufacturer as based on the patient's weight and dose.**
- For all doses, dilute to a final concentration of 50 mg/mL in an infusion bag using 0.9% sodium chloride
- Infuse through 0.2 or 0.22 micron filter
- Refill for 12 months unless otherwise noted: _____

☐ New Start:

- ☐ **Weight 40kg-59kg:** 2400mg IV at Week 0, then Ultomiris 3000mg IV at Week 2 and every 8 weeks thereafter
- ☐ **Weight 60kg-99kg:** 2700mg IV at Week 0, then Ultomiris 3300mg IV at Week 2 and every 8 weeks thereafter
- ☐ **Weight ≥ 100kg:** 3000mg IV at Week 0, then Ultomiris 3600mg IV at Week 2 and every 8 weeks thereafter

☐ Maintenance:

- ☐ **Weight 40kg-59kg:** 3000mg IV every 8 weeks
- ☐ **Weight 60kg-99kg:** 3300mg IV every 8 weeks
- ☐ **Weight ≥ 100kg:** 3600mg every 8 weeks

☐ Other: _____

PRE-MEDICATION

Note: pre-meds not typically indicated for Ultomiris

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ famotidine (Pepcid) 20 mg IV
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
- ☐ Other: _____
Dose: _____ Route: _____

LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other: _____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

SPECIAL INSTRUCTIONS

Ordering Provider (Print)	Provider Signature	Provider NPI	Date
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- ☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS (Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)

- ☐ Arbor Infusion Fishers (317) 981-1772