

ULTOMIRIS (RAVULIZUMAB-CWVZ) PATIENT REFERRAL AND PRESCRIPTION SHEET

Patient Information			
Patient Name:		Date:	
DOB:		Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm
Allergies:		Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
Primary Diagnosis			
Diagnosis	ICD-10	Diagnosis	ICD-10
<input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria	D59.5	<input type="checkbox"/> Generalized Myasthenia Gravis	G70.00
<input type="checkbox"/> Atypical Hemolytic Uremic Syndrome	D59.39	<input type="checkbox"/> Neuromyelitis Optica Spectrum Disorder	G36.0
<input type="checkbox"/> Other: _____			
Medication Order			
Loading Dose <input type="checkbox"/> Infuse 2400mg IV x 1 dose (pt weight 40-59kg) <input type="checkbox"/> Infuse 2700mg IV x 1 dose (pt weight 60-99kg) <input type="checkbox"/> Infuse 3000mg IV x 1 dose (pt weight ≥100kg) <input type="checkbox"/> Other _____			<input type="checkbox"/> Refills x one year from date of signature unless indicated below <input type="checkbox"/> _____ Refills
Maintenance Dose <input type="checkbox"/> Infuse 3000 mg IV every 8 weeks after loading dose (pt weight 40-59kg) <input type="checkbox"/> Infuse 3300 mg IV every 8 weeks after loading dose (pt weight 60-99kg) <input type="checkbox"/> Infuse 3600mg IV every 8 weeks after loading dose (pt weight ≥100kg) <input type="checkbox"/> Other _____			
Nursing Orders Skilled nursing visit for clinical assessment, administration of medication. Initiate plan of treatment for ongoing nursing services. Insert or access and maintain access device as indicated in Ancillary Orders. Remove peripheral IV or access from implanted VAD when infusion is completed.			
Ancillary Orders			
Pre-medications: <input type="checkbox"/> Diphenhydramine: 25mg PO 30 min pre-infusion <input type="checkbox"/> Acetaminophen: 650mg PO 30 min pre-infusion <input type="checkbox"/> Famotidine: 20 mg PO x1 dose <input type="checkbox"/> Other pre-meds: _____ <input type="checkbox"/> Refill x one year		IV Flush Orders: <input type="checkbox"/> Peripheral: NS 1-3 mL before/after use <input type="checkbox"/> Implanted VAD: NS 5 to 10 mL before/after use and 10 mL post-lab draw. Heparin (100 unit/mL) 3 to 5 mL final flush <input type="checkbox"/> CVAD: NS 5 to 10 mL before/after use and 10 mL post-lab draw Heparin (10 units/mL) 3 to 5 mL final flush <input type="checkbox"/> Refill x one year	
<input type="checkbox"/> Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack: Adult: 0.3mg Children: 0.15 mg Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. Refill x 1yr			
Therapy Specific Documentation		Other Required Documentation	
Please include the following lab results <input type="checkbox"/> MuSK Test <input type="checkbox"/> ACHR Test <input type="checkbox"/> MG-ADL Score <input type="checkbox"/> Meningococcal Vaccines (MenACWY and MenB) <input type="checkbox"/> Other _____		<input type="checkbox"/> Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise. <input type="checkbox"/> H&P OR progress note(s) <input type="checkbox"/> Medication List (include prior/failed DMARDS, biologics, or steroid use)	
Provider Information			
Provider Name:		Provider Phone:	
Provider NPI:		Provider Fax:	
Is the provider enrolled in Ultomiris REMS Program? If not, please register at www.ultsolrems.com			
Provider Address:			

I authorize KabaFusion and its representatives to act as an agent and initiate and execute any insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to KabaFusion.

Prescriber Signature: _____

Date: _____

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