Ultomiris (ravulizumab-cwvz)
Patient Referral and Prescription Sheet

KabaFusion
Patient-Focused Infusion Therapy

Worcester, MA

Fax Completed Form To: 888.966.0416

Phone: 888.727.2323

Patient Information

Patient Name:	**Date:**	
DOB:	**Height:**	❑ **inches** ❑ **cm**
Allergies:	**Weight:**	❑ **lbs** ❑ **kg**

Primary Diagnosis

Diagnosis	**ICD-10**	**Diagnosis**	**ICD-10**
❑ Paroxysmal Nocturnal Hemoglobinuria	D59.5	❑ Generalized Myasthenia Gravis	G70.00
❑ Atypical Hemolytic Uremic Syndrome	D59.39	❑ Neuromyelitis Optica Spectrum Disorder	G36.0
❑ Other:			

Medication Order

Loading Dose
❑ Infuse 2400mg IV x 1 dose (pt weight 40-59kg)
❑ Infuse 2700mg IV x 1 dose (pt weight 60-99kg)
❑ Infuse 3000mg IV x 1 dose (pt weight ≥100kg)
❑ Other _____

Maintenance Dose
❑ Infuse 3000 mg IV every 8 weeks after loading dose (pt weight 40-59kg)
❑ Infuse 3300 mg IV every 8 weeks after loading dose (pt weight 60-99kg)
❑ Infuse 3600mg IV every 8 weeks after loading dose (pt weight ≥100kg)
❑ Other _____

❑ Refills x one year from date of signature unless indicated below

❑ _____ **Refills**

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:
❑ Diphenhydramine: 25mg PO 30 min pre-infusion
❑ Acetaminophen: 650mg PO 30 min pre-infusion
❑ Famotidine: 20 mg PO x1 dose
❑ Other pre-meds: _____
❑ **Refill x one year**

IV Flush Orders:
❑ Peripheral: NS 1-3 mL before/after use
❑ 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
❑ 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
❑ **Refill x one year**

❑ **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

Please include the following lab results

❑ MuSK Test
❑ ACHR Test
❑ MG-ADL Score
❑ Meningococcal Vaccines (MenACWY and MenB)
❑ Other _____

Other Required Documentation

❑ Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise.
❑ H&P **OR** progress note(s)
❑ 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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