Site of Care

☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

ULTOMIRIS (RAVULIZUMAB-CWVZ) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number: _____

Patient Weight: _____ Patient Height: _____ Allergies: _____

Other Medications: _____

DIAGNOSIS (Provider must specify)

☐ Myasthenia Gravis without acute exacerbation, ICD10: G70.00

☐ Myasthenia Gravis with acute exacerbation, ICD10: G70.01

☐ Paroxysmal Nocturnal Hemoglobinuria (PNH), ICD10: D59.5

☐ Atypical Hemolytic Uremic Syndrome (aHUS), ICD 10: D59.3

☐ Neuromyelitis Optica Spectrum Disorder (NMOSD) With positive anti-aquaporin-4 (AQP4) antibody ICD10: G36.0

☐ Other:_____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Benadryl 25mg PO ☐ Methylprednisolone (Solu-Medrol) _____ mg IVP

☐ Other: _____ Dose: _____ Route: _____

☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
ULTOMIRIS	☐ Weight 40-59 kg: 2,400 mg on week 0,2, then 3,000 mg every 8 weeks. ☐ Weight 60-99 kg: 2,700 mg on week 0,2 then 3,300 mg every 8 weeks. ☐ Weight 100 kg or greater: 3,000 mg on week 0,2, then 3,600 mg every 8 weeks.	IV	☐ Loading dose: Week 0 and 2 ☐ Maintenance dose: Every 8 weeks

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____ Contact: _____

Phone: _____ Fax: _____ Email Address:_____

Signature: _____ Date: _____