ULTOMIRIS
(ravulizumab)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

• Is referring provider enrolled in the FDA REMS program? ☐ Y ☐ N

PRIMARY DIAGNOSIS

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

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Ultomiris.
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

• Has the patient completed the full meningococcal vaccination series? ☐ Y ☐ N
• 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 ☐

*Prophylactic antibiotic coverage is recommended if starting Ultomiris prior to completion of the vaccine series. This is at the discretion of, and managed by, the referring provider.

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

☐ Ultomiris _____mg IV every _____weeks
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____

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