



Ultomiris Order Form

Patient Name: _____ DOB: _____
 Phone: _____ Address: _____
 City: _____ State: _____ Zip: _____ Email: _____
 Sex: _____ Height: _____ Weight: _____ Allergies: _____

DIAGNOSIS:

- Atypical hemolytic uremic syndrome (aHUS) ICD-10: D59.3
- Myasthenia Gravis w/out acute exacerbation (gMG) ICD-10: G70.00 Myasthenia Classification: II III IV
- Other: _____ ICD-10: _____
- Neuromyelitis optica spectrum disorder (NMOSD) ICD-10 Code: G36.00
- Paroxysmal nocturnal Hemoglobinuria (PNH) ICD-10: D59.5

ORDER FOR ULTOMIRIS (RAVULIZUMAB):

Initial Dose with Maintenance (New to Therapy - Adult Patients):

- 40kg to 59kg - 2,400mg IV, followed by 3,000mg IV 2 weeks later, then 3,000mg IV every 8 weeks
- 60kg to 99kg - 2,700mg IV, followed by 3,300mg IV 2 weeks later, then 3,300mg IV every 8 weeks
- 100kg or > - 3,000mg IV, followed by 3,600mg IV 2 weeks later, then 3,600mg IV every 8 weeks

Maintenance Dose (Adult Patients):

- 40 kg to 59 kg - 3,000 mg IV every 8 weeks
- 60 kg to 99 kg - 3,300 mg IV every 8 weeks
- 100 kg or greater - 3,600 mg IV every 8 weeks

PRE-MEDICATIONS:

Pre-medications (if necessary): _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- Nevada Infusion Hypersensitivity Reaction Order Set
- Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line

FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml

NURSING: Per Nevada Infusion

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____
 Physician Signature: _____ Date: _____
 Point of Contact: _____ Phone: _____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **



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Patient Name: _____ DOB: _____

LABS ORDERS: _____ Fax results to: _____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

Meningococcal Vaccination Status:

- Primary vaccination series completed – date: _____
- MenACWY booster completed – date: _____
- MenB booster completed – date: _____

Prescriber is enrolled in the Ultomiris REMS program (**required**) Yes OR No

- Signed provider orders (page 1)
- Patient demographic and insurance information
- Patient’s current medication list
- Supporting recent clinical notes and H&P (to support primary diagnosis)
- Supporting documentation to include past tried and/or failed therapies
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy:

gMG diagnosis - please answer and/or attach the following:

- Does the patient have a positive serologic test for anti-AChR antibodies?
 - Yes OR No If yes, please attach results
- Myasthenia Gravis-Activities of Daily Living (MG-ADL) score: _____
- EMG report

PNH diagnosis - please answer and/or attach the following:

- Does the patient have GPI protein deficiencies?
 - Yes OR No If yes, please attach results - please provide flow cytometry analysis
- Does the patient have a history of failure of, contraindication, or intolerance to Empaveli (pegcetacoplan) therapy?
 - Yes OR No
- Does the patient have the presence of a thrombotic event, organ damage secondary to chronic hemolysis, high LDH activity or is the patient transfusion dependent? Yes OR No

NMOSD diagnosis - Does the patient have a positive serologic test for AQP4 antibodies?

- Yes OR No If yes, please attach results

aHUS diagnosis – has Shiga toxin E. coli and TTP been ruled out? Yes OR No

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

Point of Contact: _____ Phone: _____ Email: _____

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Nevada Infusion

Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511

Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706

PH: 775-453-0667 | Fax: 775-470-8478

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Patient Name: _____ DOB: _____

Other medical necessity: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

Point of Contact: _____ Phone: _____ Email: _____

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