

# Ultomiris (ravulizumab-cwvz)

Provider Order Form rev. 7/20/2022



www.aleracare.com  
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## PATIENT INFORMATION

Patient Name:		DOB:	
Patient Phone:		Patient Email:	
NKDA	Allergies:	Weight lbs/kg:	Height:
<b>Patient Status:</b>	New to Therapy	Continuing Therapy	Therapy Change
	Next Due Date (if applicable):		

## PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

## DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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### ICD-10 CODE

D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)  
 D59.3 Hemolytic-uremic syndrome  
 G70.00 Myasthenia Gravis  
 Other: \_\_\_\_\_

### PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO  
 cetirizine (Zyrtec) 10mg PO  
 loratadine (Claritin) 10mg PO  
 diphenhydramine (Benadryl) 25mg 50mg / PO IV IV  
 methylprednisolone (Solu-Medrol) 40mgIV 125mg IV  
 hydrocortisone (Solu-Cortef) 100mg IV  
 Other: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

### SPECIAL INSTRUCTIONS

### MEDICATION ORDER

#### Ultomiris (ravulizumab-cwvz)

Dose

**Loading Dose (this is a one time dose followed by maintenance dosing):**

600mg IV	2,400mg IV
900mg IV	2,700mg IV
1,200mg IV	3,000mg IV

#### Maintenance Dose:

300mg IV	3,000 mg IV
600mg IV	3,300 mg IV
2,100mg IV	3,600mg IV
2,700mg IV	Other: _____

Frequency (for maintenance dosing starting 2 weeks after loading dose)

Every 4 weeks  
 Every 8 weeks  
 Other: \_\_\_\_\_

Order Expiration Date (mm/dd/yy): \_\_\_\_\_  
(If not indicated order will expire one year from date signature)

Provider Name (Print)	Provider Signature	Date
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Check here if this is a stat order