immersiv HEALTH

ULTOMIRIS® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ D59.30 Hemolytic Uremic Syndrome (aHUS)

☐ D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)

☐ G36.0 Neuromyelitis optica (NMOSD)

☐ ICD-10 CODE: _____ DESCRIPTION: _____

☐ G70.00 Myasthenia Gravis without acute exacerbation

☐ G70.01 Myasthenia Gravis with acute exacerbation

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & failed Therapies ☐ Most recent History & Physical ☐ Anti-AChR or Anti-AQP4 Status ☐ Meningococcal vaccine records

MEDICATION ORDER

***For Patients Weighing 40 kg to 59 kg**

☐ **LOADING:** Ultomiris® (ravulizumab) 2400 mg IV per protocol at week 0, and 3000 mg IV at week 2

☐ **MAINTENANCE:** Ultomiris® (ravulizumab) 3000 mg IV per protocol every 8 weeks

***For Patients Weighing 60 kg to 100 kg**

☐ **LOADING:** Ultomiris® (ravulizumab) 2700 mg IV per protocol at week 0, and 3300 mg IV at week 2

☐ **MAINTENANCE:** Ultomiris® (ravulizumab) 3300 mg IV per protocol every 8 weeks

***For Patients Weighing GREATER Than 100 kg**

☐ **LOADING:** Ultomiris® (ravulizumab) 3000 mg IV per protocol at week 0, and 3600 mg IV at week 2

☐ **MAINTENANCE:** Ultomiris® (ravulizumab) 3600 mg IV per protocol every 8 weeks

☐ **OTHER:** _____

*Flush with 30 ml NS after each infusion

PRE-MEDICATIONS

PO

☐ Acetaminophen: 650 mg

☐ Cetirizine: 10 mg

☐ Diphenhydramine: 25 mg

IV

☐ Methylprednisolone: 125 mg

☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 60 minutes following each infusion.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: (IF APPLICABLE) _____ **CONTACT NAME:** _____

SIGNATURE: (NO STAMPS) _____ _____ **DATE:** _____

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN