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adaptIV infusion

Ultomiris (Ravulizumab-cwvz)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation
☐ Meningococcal vaccination (both conjugate and serogroup B) are required prior to initiating Ultomiris infusions.
☐ Check here if patient has already received vaccines. Fax or attach documentation of administered vaccines.
☐ Check here for AdaptIV Infusion to administer vaccines as outlined below.

MENINGITIS VACCINE – PATIENTS ARE REQUIRED TO RECEIVE FIRST DOSE OF BOTH THE CONJUGATE AND SEROGROUP B VACCINES PRIOR TO INITIATING ULTOMIRIS INFUSIONS.

Unless noted, vaccines will be given 2 weeks prior to starting Ultomiris. AdaptIV Infusion will schedule the patient for vaccine visit followed by Ultomiris two weeks later. If urgent Ultomiris is indicated in an unvaccinated patient, AdaptIV Infusion will administer meningococcal vaccine(s) as soon as possible including same day as Ultomiris. Additionally, provider must prescribe patients with 2 weeks of antibacterial drug prophylaxis.

☐ Check here if this is an **urgent** start.

ADAPTIV INFUSION WILL ADMINISTER BOTH VACCINES AS OUTLINED BELOW.

Meningococcal conjugate (MenACWY) vaccine

(Patient will be given either Menactra or Menveo vaccine based on availability and will receive **two doses separated by at least eight weeks.** Menactra and Menveo are not interchangeable and patient will receive same product for all doses in a series.)

Serogroup B Meningococcal (MenB) vaccine

(Patient will be given Bexsero or Trumenba vaccine based on availability and will receive either the two-dose series Bexsero at least one month apart or three-dose series Trumenba at 0, 1-2, and 6 months. Bexsero and Trumenba are not interchangeable and patient will receive same product for all doses in a series.)

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Ravulizumab-cwvz** (Ultomiris) in 0.9% sodium chloride, intravenous infusion

Indication (Choose one) ☐ PNH ☐ aHUS ☐ gMG

☐ Dose: Induction (Choose one) If patient has already completed induction dose, proceed to maintenance dose.
  ☐ 2,400mg (40kg-less than 60kg)
  ☐ 2,700mg (60kg-less than 100kg)
  ☐ 3,000mg (100kg or greater)
☐ Dose: Maintenance: (Choose one) Starting 2 weeks after the loading dose and every 8 weeks thereafter.
  ☐ 3,000mg (40kg-less than 60kg)
  ☐ 3,300mg (60kg-less than 100kg)
  ☐ 3,600mg (100kg or greater)

☐ Infuse over 35 min. in adults & 1-4 hours in pediatric patients
☐ For all doses, dilute to a final concentration of 5mg/ml in an infusion bag using 0.9% sodium chloride
☐ Infuse through 0.2 or 0.22 micron filter

☐ Patient is required to stay for 30 min. observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

Please continue to next page.

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK

adaptIV infusion

_____ / _____ / _____
Today's Date

_____
Patient Name (Print)

_____
DOB

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____
Provider Name (Print)

_____
Provider Signature

_____
Date

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK