Phone: 608-690-7210
Fax: 608-807-5179
www.MySmartInfusion.com

Location
☐ Eau Claire ☐ Weston
☐ Middleton ☐ Onalaska

Ultomiris (Ravulizumab-cwvz)
Infusion Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Atypical Hemolytic Uremic Syndrome ICD 10 Code: D59.3
☐ Paroxysmal Nocturnal Hemoglobinuria ICD 10 Code: D59.5
☐ Myasthenia Gravis, Acetylcholine Receptor Antibody Positive ICD 10 Code: G70.00

Required

Meningococcal Vaccine Status & Date: _____

Required Labs

Most recent CBC & CMP (attach results)

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO
Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
Methylprednisolone (Solu-Medrol) ☐ 125mg IV
Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV
Other: _____ Route: _____
Dose: _____ Frequency: _____

Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:
- ☒ Acetaminophen 650mg PO,
- ☒ Diphenhydramine 25mg-50mg PO or IV
- ☒ Ondansetron 4mg IV
- ☒ Sodium Chloride 0.9% 1000mL IV
- ☒ Methylprednisolone 125mg IV
- ☒ Albuterol Sulfate 2.5mg nebulized
- ☒ Oxygen 1-6LPM continuous flow
- ☒ Epinephrine 0.3mg/0.3mL IM

☐ Other: _____

☒ Manage VAD per protocol:

☒ Start/Access and Discontinue PIV/CVC

☒ Flush with NS and/or Heparin per protocol based on line type

☒ Other: _____

Ultomiris Medication Order

Refill x12 months unless otherwise noted: _____

Patient Weight: _____ KG

Induction Dosage

☐ 2,400mg IV 40kg to less than 60kg
☐ 2,700mg IV 60kg to less than 100kg
☐ 3,000mg IV 100kg or greater

Maintenance Dosage

☐ 3,000mg IV on week two, then every 8 weeks. 40kg to less than 60kg
☐ 3,300mg IV on week two, then every 8 weeks. 60kg to less than 100kg
☐ 3,600mg IV on week two, then every 8 weeks. 100kg or greater

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____