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www.MySmartInfusion.com

Ultomiris (Ravulizumab-cwvz) Infusion Order Form

Location

- ☐ Eau Claire ☐ Weston
☐ Middleton ☐ Onalaska

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.

- | | |
|--|---|
| <input checked="" type="checkbox"/> Administer the following emergency medications per Smart Infusion Therapy Services protocol: <ul style="list-style-type: none"><input checked="" type="checkbox"/> Acetaminophen 650mg PO,<input checked="" type="checkbox"/> Diphenhydramine 25mg-50mg PO or IV<input checked="" type="checkbox"/> Ondansetron 4mg IV<input checked="" type="checkbox"/> Sodium Chloride 0.9% 1000mL IV<input checked="" type="checkbox"/> Methylprednisolone 125mg IV<input checked="" type="checkbox"/> Albuterol Sulfate 2.5mg nebulized<input checked="" type="checkbox"/> Oxygen 1-6LPM continuous flow<input checked="" type="checkbox"/> Epinephrine 0.3mg/0.3mL IM <input type="checkbox"/> Other: _____ | <input checked="" type="checkbox"/> Manage VAD per protocol: <ul style="list-style-type: none"><input checked="" type="checkbox"/> Start/Access and Discontinue PIV/CVC<input checked="" type="checkbox"/> Flush with NS and/or Heparin per protocol based on line type<input checked="" type="checkbox"/> Other: _____ |
|--|---|

Ultomiris Medication Order

Refill x12 months unless otherwise noted: _____

Patient Weight: _____ KG

Induction Dosage

- ☐ 2,400mg IV
☐ 2,700mg IV
☐ 3,000mg IV

Maintenance Dosage

- ☐ 3,000mg IV on week three, then every 8 weeks
☐ 3,300mg IV on week three, then every 8 weeks
☐ 3,600mg IV on week three, then every 8 weeks

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: _____