PRESCRIPTION ORDER FORM

ULTOMIRIS
(ravulizumab)

Suite Life
Infusing health and wellness into your life.
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

• Is referring provider enrolled in the FDA REMS program? ☐ Y ☐ N
• Has the patient received the 1st dose of meningococcal vaccine series? ☐ Y ☐ N Date:_____
• If not started, check here for infusion clinic to administer vaccine series:☐

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)
☐ D59.5 Paraxysmal Nocturnal Hemoglobinuria (PNH)
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/ diff & ANC: _____ ☐ LFT's at month 2 then every 3 months after ☐ Other: _____

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP ☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP
☐Solu-Medrol 40mg IVP ☐Solu-Cortef 125mg IVP ☐ Tylenol 650mg PO ☐ Other: _____

PRIMARY MEDICATION ORDER

Weight 40kg-59kg:
☐ Ultomiris 2400mg IV at week 0, then Ultomiris 3000mg IV at week 2 and every 8 weeks thereafter
Weight 60kg-99kg:
☐ Ultomiris 2700mg IV at week 0, then Ultomiris 3300mg IV at week 2 and every 8 weeks thereafter
Weight ≥ 100kg:
☐ Ultomiris 3000mg IV at week 0, then Ultomiris 3600mg IV at week 2 and every 8 weeks thereafter
☐ Ultomiris _____mg IV every _____weeks follow infusion rate per manufacturer
☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____