Phone: (847) 324-6800 Fax: (224) 251-7141 Email: intake@infusacare.com

InfusaCare
MedFuse

Ultomiris (Ravulizumab-cwvz) Infusion Order

Patient Name: DOB: □ Male □ Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication

□ Acetaminophen _____mg by □ PO
□ Ceterizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ Proof of Meningitis Vaccines (both conjugate and serogroup)
□ ACH Antibody positive
□ CBC/CMP
□ Brain MRI within the last 6 months
□ Other:

Ultomiris is a weight based drug:

Patient Height (cm): Patient Weight (kg):

Ultomiris Medication Order (Please select ONE):

□ Induction dosing on week 0, 2 followed by maintenance:
- Dosing for week 0 (Please choose one):
  - □ 2400 mg (40kg—59.9kg)
  - □ 2700 mg (60kg—99.9kg)
  - □ 3000 mg (>100kg)
- Maintenance Dosing for week 2 and every 8 weeks after (Please choose one):
  - □ 3000 mg (40kg—59.9kg)
  - □ 3300 mg (60kg—99.9kg)
  - □ 3600 mg (>100kg)

□ Maintenance dosing every 8 weeks only
- Dosing (Please choose one)
  - □ 3000 mg (40kg—59.9kg)
  - □ 3300 mg (60kg—99.9kg)
  - □ 3600 mg (>100kg)

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Updated: 4/1/2024