



159 Fountains Blvd.
Madison, MS 39110
Phone: 601-859-8200 Fax:601-859-8201

**ULTOMIRIS (RAVULIZUMAB-CWVZ)
INFUSION ORDERS**

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis and including past tried and/or failed therapies intolerance, outcomes or contraindications to conventional therapy
- Positive serologic test for anti-AChR antibodies (if Myasthenia Gravis diagnosis)
- Vaccine Records, specifically recommended for Meningococcal Disease vaccine

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- Paroxysmal nocturnal hemoglobinuria (PNH) (ICD-10:_____)
- Atypical hemolytic uremic syndrome (aHUS) (ICD-10:_____)
- Myasthenia Gravis (gMG) with AchR antibody positive (ICD-10:_____)

J Code: 1303

Patient Weight: _____ Kg

ULTOMIRIS ORDERS

PNH, aHUS, and gMG Adult Dosing

Initial dosing with maintenance (new patients):

40kg to 59kg - 2,400mg IV loading dose, followed by 3,000mg IV maintenance 2 weeks later, then 3,000mg IV every 8 weeks
 60kg to 99kg - 2,700mg IV loading dose, followed by 3,300mg IV maintenance 2 weeks later, then 3,300mg IV every 8 weeks
 100kg or greater - 3,000mg IV loading dose, followed by 3,600mg IV maintenance 2 weeks later, then 3,600mg IV every 8 weeks

Maintenance dosing:

40kg to 59kg - 3,000mg IV every 8 weeks
 60kg to 99kg - 3,300mg IV every 8 weeks
 100kg or greater - 3,600mg IV every 8 weeks

Required:

- Yes No Patient has had the meningococcal vaccine
- Yes No Physician is enrolled in ultomiris rems program

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	