

Ravulizumab-cwvz (Ultomiris) p1

Provider Order Form rev. 08/21/2023

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight (lbs/kg):	Height:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Last Treatment Date:	Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 05.01.2023)
- Meningococcal vaccination (both conjugate and serogroup B) ~~is~~ required prior to initiating Ultomiris infusions.
- Check here if patient has already received vaccines. Fax or attach documentation of administered vaccines.
- Check here for IVX to administer vaccines as outlined below.

MENINGITIS VACCINE - PATIENTS ARE REQUIRED TO RECEIVE FIRST DOSE OF BOTH THE CONJUGATE AND SEROGROUP B VACCINES PRIOR TO INITIATING ULTOMIRIS INFUSIONS.

Unless noted, vaccines will be given 2 weeks prior to starting Ultomiris. IVX will schedule the patient for vaccine visit followed by Ultomiris two weeks later. If **urgent** Ultomiris is indicated in an unvaccinated patient, IVX will administer meningococcal vaccine(s) as soon as possible including same day as Ultomiris. Additionally, provider **must prescribe** patients with 2 weeks of antibacterial drug prophylaxis.

- Check here if this is an **urgent** start.

IVX WILL ADMINISTER BOTH VACCINES AS OUTLINED BELOW.

Meningococcal conjugate (MenACWY) vaccine

(Patient will be given either Menactra or Menveo vaccine based on availability and will receive **two doses separate by at least eight weeks**. Menactra and Menveo are not interchangeable and patient will receive same product for all doses in a series.)

Serogroup B Meningococcal (MenB) vaccine

(Patient will be given Bexsero or Trumenba vaccine based on availability and will receive either the two-dose series Bexsero at least one month apart or three-dose series Trumenba at 0, 1-2, and 6 months. Bexsero and Trumenba are not interchangeable and patient will receive same product for all doses in a series.)

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV
- methylprednisolone (Solu-Medrol) 40mg / 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- Other: _____

THERAPY ADMINISTRATION

- Ravulizumab-cwvz** (Ultomiris) in 0.9% sodium chloride, intravenous infusion

Indication (Choose one) PNH aHUS gMG

- Dose: Induction** (Choose one) If patient has already completed induction dose, proceed to maintenance dose.
 - 2,400mg (40kg-less than 60kg)
 - 2,700mg (60kg-less than 100kg)
 - 3,000mg (100kg or greater)
- Dose: Maintenance:** (Choose one) Starting 2 weeks after the loading dose and every 8 weeks thereafter.
 - 3,000mg (40kg-less than 60kg)
 - 3,300mg (60kg-less than 100kg)
 - 3,600mg (100kg or greater)

- Infuse over 35 min. in adults & 1-4 hours in pediatric patients
 - For all doses, dilute to a final concentration of 5mg/ml in an infusion bag using 0.9% sodium chloride
 - Infuse through 0.2 or 0.22 micron filter
- Patient is required to stay for 60 min. observation
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

Please continue to next page.

Ravulizumab-cwvz (Ultomiris) p2



Provider Order Form rev. 08/21/2023

Date: _____ Patient Name: _____ DOB: _____

SPECIAL INSTRUCTIONS

Provider Name (Print) _____ Provider Signature _____ Date _____

FAX NUMBERS

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> AUSTIN: 512-772-2824 | <input type="checkbox"/> CONNECTICUT: 860-955-1532 | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> NORTH CENTRAL FL: 352-756-4191 | <input type="checkbox"/> RALEIGH: 919-287-2551 |
| <input type="checkbox"/> BAY AREA: 844-889-0275 | <input type="checkbox"/> DAYTONA: 386-259-6096 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> NORTH JERSEY: 551-227-2823 | <input type="checkbox"/> SAN ANTONIO: 726-238-9950 |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143 | <input type="checkbox"/> DELAWARE: 302-596-8553 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> NORTHWEST AR: 888-615-1445 | <input type="checkbox"/> SARASOTA: 941-870-6550 |
| <input type="checkbox"/> CHICAGO: 312-253-7244 | <input type="checkbox"/> EAST TN: 615-425-7427 | <input type="checkbox"/> LAKELAND: 863-316-3910 | <input type="checkbox"/> ORLANDO: 844-946-0867 | <input type="checkbox"/> SOUTH JERSEY: 856-519-5309 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> FT. LAUDERDALE: 754-946-2052 | <input type="checkbox"/> LITTLE ROCK: 501-451-5644 | <input type="checkbox"/> PALM BEACH: 561-768-9044 | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 |
| <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> MIAMI: 786-744-5687 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> TAMPA: 844-946-0849 |
| | <input type="checkbox"/> HOUSTON: 832-631-9595 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 | <input type="checkbox"/> PIEDMONT TRIAD: 336-790-2200 | <input type="checkbox"/> WEST TN: 888-615-1445 |