MONTGOMERY CANCER CENTER
A BAPTIST MEDICAL CENTER SOUTH FACILITY

MEDICATION ORDERS

RAVULIZUMAB-CWVZ **(ULTOMIRIS)**

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
❑ New Referral ❑ Dose or Frequency Change ❑ Order Renewal

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: ❑ Montgomery ❑ Prattville

DIAGNOSIS AND ICD 10 CODE	
❑ Myasthenia Gravis without (acute) exacerbation	ICD 10 Code: G70.00
❑ Myasthenia Gravis with (acute) exacerbation	ICD 10 Code: G70.01
❑ Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.9
❑ Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code: G36.0
❑ Hemolytic-uremic Syndrome (aHUS)	ICD 10 Code: D59.3

REQUIRED DOCUMENTATION/TESTING	
❑ This signed order form by the provider ❑ Patient demographics AND insurance information	❑ Clinical/Progress notes supporting primary diagnosis ❑ Acetylcholine Receptor Antibody test results (if Myasthenia Gravis) ❑ Documentation of meningococcal vaccines (include dates)
Is your patient enrolled in the UltSolREMS program? ❑ YES ❑ NO Is the ordering PROVIDER enrolled in the UltSolREMS program? ❑ YES ❑ NO (if no, must be enrolled to start therapy)	
List Tried & Failed Therapies (if Myasthenia Gravis): 1) 2)	

MEDICATION ORDERS	
Initial Dosing	❑ 2,400mg IV (40k to less than 60kg) ❑ 2,700mg IV (60K to less than 100kg) ❑ 3,000mg IV (100k or greater)
Maintenance Dosing	❑ 3,000mg (40k to less than 60kg) IV every 8 weeks starting 2 weeks after initial load ❑ 3,300mg (60k to less than 100kg) IV every 8 weeks starting 2 weeks after initial load ❑ 3,600mg (100k or greater kg) IV every 8 weeks starting 2 weeks after initial load
Refills: ❑ x 6 months ❑ x 1 year ❑ _____ doses • New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines. • Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.	

Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first dose of Ultomiris, unless the risks of delaying Ultomiris therapy outweigh the risk of developing a meningococcal infection. For patients who are not up to date with meningococcal vaccines at least two weeks prior to initiation of treatment and who must start ULTOMIRIS or SOLIRIS urgently: Provide the patient with a prescription for antibacterial drug prophylaxis. Comply with the most current National Advisory Committee on Immunization (NACI) recommendations for meningococcal vaccination in patients with complement deficiencies.

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207