ULTOMIRIS® (ravulizumab-cwvz) Order/Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

Phone: (414) 460-3195
Fax: (414) 763-0063
www.gtinfusions.com

Patient Information

Patient Name:	Patient DOB:

Referral Status

☐ New Referral ☐ Restart/Continuation ☐ Medication/Order Change ☐ D/C Infusions

Diagnosis and ICD 10 Code

☐ Generalized Myasthenia Gravis (gMG) without (acute) exacerbation	ICD 10 Code: G70.00
☐ Generalized Myasthenia Gravis (gMG) with (acute) exacerbation	ICD 10 Code: G70.01
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5
☐ Atypical Hemolytic Uremic Syndrome (aHUS)	ICD 10 Code: D59.3
☐ Other Diagnosis:	ICD 10 Code:

Supporting Documentation

☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s) – front & back	☐ Labs and tests including baseline liver function test
☐ Tried and Failed therapies	☐ Current Medication List

Vaccine

Meningitis Vaccine: Patient received first dose of Conjugate (MenACWY) and serogroup b (MenB) ☐ Yes ☐ No (If No, complete the following):
☐ Office will administer MenACWY and MenB Vaccines
☐ GT administers Meningococcal conjugate (MenACWY) Vaccine and Serogroup B Meningococcal (MenB) Vaccine: Menactra OR Menveo - two doses separated by 8 weeks, 1 dose booster after 5 years AND Bexsero - 2 doses separated by 1 month OR Trumenba - 3 doses at 0, 1-2 and 6 months, 1 year after primary administration and every 2-3 years thereafter. Vaccines will be given 2 weeks before starting Ultomiris infusion. If urgent Ultomiris administration is needed in unvaccinated patient, please contact us.

Medication Orders

Loading and Maintenance Dose:
☐ **30 kg to less than 40 kg:** ULTOMIRIS® 1,200 mg IV loading dose at week 0, followed by 2,700 mg IV at week 2, and every 8 weeks thereafter.
☐ **40 kg to less than 60 kg:** ULTOMIRIS® 2,400 mg IV loading dose at week 0, followed by 3,000 mg IV at week 2, and every 8 weeks thereafter.
☐ **60 kg to less than 100 kg:** ULTOMIRIS® 2,700 mg IV loading dose at week 0, followed by 3,300 mg IV at week 2, and every 8 weeks thereafter.
☐ **100 kg or greater:** ULTOMIRIS® 3,000 mg IV loading dose at week 0, followed by 3,600 mg IV at week 2, and every 8 weeks thereafter.

Premedication

☐ Acetaminophen (PO): ☐ 500mg, ☐ 650mg, ☐ 1,000mg **OR** Ibuprofen (PO): ☐ 200mg, ☐ 400mg, ☐ 600mg
☐ Loratadine 10mg (PO) **OR** ☐ Diphenhydramine (PO): ☐ 25mg, ☐ 50mg
☐ Famotidine 20mg (PO) prior to methylprednisolone
☐ Methylprednisolone IV: ☐ 125mg, ☐ 250mg, ☐ 500mg, ☐ 1,000 mg, ☐ Other: _____ mg
☐ Hydrocortisone Sodium Succinate (Solu Cortef) 100 mg IVP
☐ Other (medication, dose, route, and frequency): _____

Labs

☐ CMP – frequency: _____ ☐ BMP – frequency: _____ ☐ HBV – frequency: _____ ☐ HIV – frequency: _____
☐ CBC w/o diff - frequency: _____ ☐ CBC w/diff - frequency: _____ ☐ CBC w/man diff - frequency: _____
☐ Serum Quantitative Immunoglobulins – frequency: _____
☐ Stratify™ JCV Antibody (with Index) with Reflex to Inhibition Assay – frequency: _____
☐ Urine pregnancy test prior to each infusion
☐ Other labs (e.g. thyroid, Blood Glucose) and frequency: _____

Notes (Additional Info)

Adverse and anaphylactic reactions and post infusion will be treated per Gamma Therapeutic Center protocol.

Prescriber Information

Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order valid for one year)

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.