Ascension St. Vincent's

Outpatient infusion center
Phone 904-296-5994 Fax 904-296-9070

Patient Name: _____
Date of Birth: _____
Patient Phone number: _____
Insurance: _____
Subscriber ID: _____
Infusion Site: _____

Ravulizumab (Ultomiris) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information						
Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List:_____

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐Atypical hemolytic uremic syndrome ☐Myasthenia gravis, generalized ☐Neuromyelitis optica spectrum disorder ☐Paroxysmal nocturnal hemoglobinuria ☐ Other:_____	☐D59.39 ☐G70.00 ☐G36.0 ☐D59.5 ☐ Other:_____	☐ J1303	☑ CPT Code: _____

Labs

Prior to scheduling initial infusion:
☑ BMP
☑ CBC
☑ serum LDH
Other Labs:
☐ _____
☐ _____
☐ _____

Follow up labs and frequency:
☐ _____
☐ _____
☐ _____

Notes to Prescriber (prior to initiating therapy)

- Prescriber and patient must be enrolled in the REMS program
- Prescriber to counsel patients on the risk of meningococcal infection; ensure patients are vaccinated and provide educational materials.
- Patients should be up to date with all immunizations before initiating therapy
- If urgent ravulizumab initiation is necessary in a patient that is not up to date with meningococcal vaccines according to current guidelines, provide antibacterial prophylaxis and administer vaccines as soon as possible.
- To reduce the risk for meningococcal disease, consider antimicrobial prophylaxis with oral antibiotics (penicillin, or macrolides if penicillin-allergic) for the duration of ravulizumab therapy

Nursing Orders

☑ Discharge patient when stable and meets protocol criteria
☑ Decrease infusion rate or discontinue for infusion reactions and notify the prescriber
☑ Monitor for at least 1 hour following completion of infusion (for signs/symptoms of infusion reaction)
☑ Flush entire line with NS after infusion of the dose
☑ Infusion rate per manufacturer's recommendation

Emergency/Anaphylaxis Order

☑ Follow standard orders for management of allergies and anaphylaxis reactions

Pre-medications (not required)

☐ Acetaminophen 975 mg PO, once
☐ Cetirizine 10 mg PO, once
☐ Dexamethasone 20 mg IV, once
☐ Ondansetron 4 mg IV, once
☐ Diphenhydramine 25 mg PO, once
☐ Diphenhydramine 25 mg IV, once
☐ Other: _____
☐ Other: _____

Medication Orders*

	Medication	Route	Dose/Frequency

☑	Ravulizumab (Ultomiris)	IV	Initial dosing with maintenance (new adult patients): ☐ 40kg to 59kg - 2,400mg IV, followed by 3,000mg IV 2 weeks later, then 3,000mg IV every 8 weeks ☐ 60kg to 99kg - 2,700mg IV, followed by 3,300mg IV 2 weeks later, then 3,300mg IV every 8 weeks ☐ 100kg or > - 3,000mg IV, followed by 3,600mg IV 2 weeks later, then 3,600mg IV every 8 weeks ☐ Other: __ mg IV, followed by ___ mg IV __ weeks later, then ___ mg IV every __ weeks Maintenance dosing only (adult): ☐ 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 ☐ Other: _____ mg IV every ___ weeks Supplemental dose following plasma exchange (PE), plasmapharesis (PP), or IV immune globulin (IVIG): ☐_____ mg IV following PE/PP/IVIG (circle one). To be administered within 4 hours following completion of PE/PP/IVIG _____ **REFILLS:** ☐ Zero / ☐ for 12 months / ☐ Other: _____ **(if not indicated order will expire one year from date signed)**

* Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Infusion Center Staff Please fax infusion records or discharge summary to:	**Fax Number**_____

Provider Signature		**Date**	
Provider Printed Name			