City Infusions
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Phone: 703-375-9577 Fax: 703-839-9750

ULTOMIRIS (RAVULIZUMAB-CWVZ) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____ kg

Allergies: _____

❑ Comments: _____

☐ New Start Therapy | ☐ Continuation of Therapy & Date of last dose (if applicable): _____

DIAGNOSIS (Provider must specify)

☐ Generalized Myasthenia Gravis (gMG), AChR Ab+ (without acute exacerbation), ICD 10: G70.00
☐ Generalized Myasthenia Gravis (gMG), AChR Ab+ (with acute exacerbation), ICD 10: G70.01
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH), ICD 10: D59.5
☐ Atypical Hemolytic Uremic Syndrome (aHUS), ICD 10: D59.39
☐ Neuromyelitis optica spectrum disorder (NMOSD) who are anti-aquaporin-4 (AQP4) antibody positive, ICD 10: G36.0
☐ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs/tests supporting diagnosis ❑ Meningococcal vaccination ≥ 2 weeks prior to first dose (Must be current per ACIP with both MenACWY & MenB)

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO
❑ Famotidine 20 mg IV
❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
❑ Benadryl 25mg PO
❑ Cetirizine (Zyrtec) 10 mg PO
❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	BODY WEIGHT (KG)	LOADING DOSE (MG)	MAINTENANCE DOSE (MG)**	ROUTE
Ultomiris	40 to less than 60	2400	3000 every 8 weeks	IV
	60 to less than 100	2700	3300 every 8 weeks	
	100 or greater	3000	3600 every 8 weeks	

**First maintenance dose is 2 weeks after the initial loading dose. Following maintenance doses are every 8 weeks.

OTHER NOTES

Order valid for 1 year from date of signature unless otherwise specified here: _____