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| ADULT AMBULATORY INFUSION ORDER  **Ravulizumab-cwvz (ULTOMIRIS)** |   **NAME:** **BIRTHDATE:** *Affix Patient Identification Label Here* |
| **ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (**  **) TO BE ACTIVE.**  |

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

Provider Information

\***Please fax a copy of the** □Demographics □ Insurance Information □ Current Lab Results

**following patient information**: □ H & P Relevant to Diagnosis □ Last infusion note □ Current Medications

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs/kg Height: \_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_\_

 Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\* Patients must receive the following meningococcal vaccine at least 2 weeks prior to treatment initation:**

1. Meningococcal serogroups A, C, W, Y vaccine (MenACWY)-Menactra or Menveo. These require a booster every 5 years.

Date of last vaccination: \_\_\_\_/\_\_\_\_/\_\_\_\_ □ Copy Attached

1. Meningococcal serogroup B vaccine-Bexsero or Trumenba. No booster vaccination is required after series is completed.

Date of last vaccination: \_\_\_\_/\_\_\_\_/\_\_\_\_ □ Copy Attached

1. Meningococcal polysaccharide vaccines given on (dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Copy Attached

Labs:

□ CBC w/diff □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ CMP □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MC2816 (03/24)

□ Urine Micro □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_\_□ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No labs needed

Pre-medications:

Diphenhydramine: □ IV □ 50mg

Acetaminophen: □ PO □ 1000 mg

Solu-Medrol: □ IV □ 1000 mg

Other: □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No Pre-Medications

□ 30 minutes wait time following pre-medications

**Administer Ultomiris IV**

* **\*\*Use 0.2 micron filter for administration\*\***

**Loading Dose:**

* **Weight: 40-59.9 kg □ 2400 mg (in 24 mL NS) over 48 minutes**
* **Weight: 60-99.9 kg □ 2700 mg (in 27 mL NS) over 36 minutes**
* **Weight: 100 kg or more □ 3000 mg (in 30 mL NS) over 24 minutes**

**Maintenance Dose:**

* **Weight: 40-59.9 kg □ 3000 mg (in 30 mL NS) over 54 minutes.**
* **Weight: 60-99.9 kg □ 3300 mg (in 33 mL NS) over 42 minutes.**
* **Weight: 100 kg or more □ 3600 mg in (36 mL NS) over 30 minutes.**

**Interval:**

* **Every 8 weeks beginning 2 weeks after loading dose**
* **Every 8 weeks beginning on date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Switching from Soliris □ Administer loading dose 2 weeks after last dose of Soliris maintenance infusion.**

 **Then**

 **□ Administer maintenance dose of Ultomiris every 8 weeks.**

* **Patient is required to stay for 60 minute observation post infusion.**
* **Patient is NOT required to stay for observation time.**