Ultomiris®

Referring Physician Orders Rev. 3/2025

Please fax completed referral form & all required documents to 770-618-9617

CPS INFUSION

PATIENT DEMOGRAPHICS

Insurance Information: Please attach copy of insurance card* front and back *(required)

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

DIAGNOSIS*

ICD-10 CODE *(required)* ***Please complete 2nd and 3rd digits to complete ICD-10 for billing***

☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria
☐ D59.30 Hemolytic Uremic Syndrome
☐ Other: _____, ICD-10 _____
☐ G70.00 Myasthenia Gravis without acute exacerbation
☐ G70.01 Myasthenia Gravis with acute exacerbation

INFUSION ORDERS

MEDICATION

Ultomiris® (ravulizumab)

DOSE

Loading:
☐ 40 to <60kg: 2400mg
☐ 60 to <100kg: 2700mg
☐ ≥100kg: 3000mg

Maintenance:
☐ 40 to <60kg: 3000mg
☐ 60 to <100kg: 3300
☐ ≥100kg: 3600mg

DIRECTIONS/DURATION

☐ Loading Infuse IV x 1 dose.
☐ Maintenance: Infuse I every 8 weeks x 1 year. Using Ultomiris® 100 mg/ml vials: Infuse loading dose at max rate of 90 mL/hr and maintenance doses at max rate of 95 mL/hr for patients weighing 60 to <100 kg. (Final diluted bag concentration = 50 mg/mL) **Infusion rate for all other patient body weight or vial concentration will be determined in accordance with manufacturer guidelines."* *Observe patient for 1 hour after completion of infusion.*

Is patient currently receiving therapy above from another facility? ☐ NO ☐ YES
If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment:

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time
☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

PRE-MEDICATION ORDERS:

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IV
☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

TEST RESULTS *(required)*

- Hepatitis B Screening for Ocrevus (submit results to start therapy)
- JC virus (JCV) antibody testing for Tysabri (submit results to start therapy and every 6 months to continue therapy)
  - Continuation labs to be done by: ☐ Infusion Center ☐ Referring Physician
- Meningococcal vaccination for Soliris (must be completed at least 2 weeks prior to starting therapy)

DIAGNOSTIC TEST RESULTS (please attach copy for all items checked)

For ALS:
☐ ALS Functional Rating Scale-revised (ALSFRS-r)
☐ Pulmonary function test

For CIDP:
☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests
☐ Lumbar puncture test
☐ Nerve biopsy report
☐ Neurological Rankin Scale Score

For MMN:
☐ Electromyography (EMG) and Nerve conduction velocity (NCV) tests
☐ anti-GM1 antibodies
☐ Lumbar puncture test

For Myasthenia Gravis:
☐ Acetylcholine receptor (AChR) antibodies
☐ Baseline MG-Activities of Daily Living (MG-ADL) Evaluation

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____