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600 W Main Street
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Troy, OH 45373
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**Washington Township Infusion Center**
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Dayton, OH, 45459
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# Ultomiris® (ravulizumab) Order Form

Epic Referral: REF115226

**Patient Name:** _____ **DOB:** _____

**Address:** _____

**Phone:** _____ **ICD-10 Diagnosis:** _____

**Patient Weight:** _____ **(include unit lbs/kg)** **Date weight taken:** _____

**Loading dose (Only check if new to Ultomiris or restarting therapy):**

☐ IV Ultomiris® (ravulizumab) _____ mg diluted in an equal volume of 0.9% NaCl infused x 1 dose followed by maintenance dosing below beginning 2 weeks after loading dose

- Volume and infusion time will be determined based on recommendations from package insert

**Maintenance:**

☐ IV Ultomiris® (ravulizumab) _____ mg diluted in an equal volume of 0.9% NaCl infused every 8 weeks

- Volume and infusion time will be determined based on recommendations from package insert

**Order good for:** ☐ **6 months** ☐ **1 year** **Other duration:** _____

**Vaccines (please attach all vaccine records):**

MenB

☐ Previous doses _____ ☐ First dose given, complete series with Bexsero/ Trumenba
☐ Give Bexsero vaccine series (2 doses ≥ 1 month apart)
☐ Meningitis group B booster at 1 year from completion of initial series

MenACWY

☐ First dose given on _____. Give second dose ≥ 2 months after first dose
☐ Give complete vaccine series (2 doses, 2nd dose ≥ 2 months after first dose)

**Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and Cathflo (2 mg) PRN for patients with a port**

***required*** ☐ **Provider is certified to prescribe through Ultomiris REMS program**

**Prescriber Printed Name:**_____ **NPI**_____

**Prescriber Full Address:** _____

**Office Phone Number:** _____ **Office Fax Number:** _____

**Prescriber Signature:** _____ **Date:** _____