BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

RAVULIZUMAB-CWVZ ORDERS (Ultomiris)

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ REMS enrollment verification for provider and patient
☐ Vaccination documentation
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change	
First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS

☐ Dx code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx

Dx Confirming Tests: ☐ PNH flow cytometry ☐ AQP4 antibody ☐ AChR antibody

☐ Documentation of meningococcal vaccination 2 weeks prior to administration

Is the ordering PROVIDER enrolled in the Ultomiris/Soliris REMS program? ☐ Yes ☐ No(must be enrolled to start therapy)

Is the PATIENT enrolled in the Ultomiris/Soliris REMS program? ☐ Yes ☐ No(must be enrolled to start therapy)

Prior Therapies:

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ Other:

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐ 650mgPO ☐ 1000mgPO	Methylprednisolone: ☐ 100mgIV ☐ 125mgIV ☐ mgIV
Diphenhydramine: ☐ 25mgPO ☐ 50mgPO ☐ 25mgIV ☐ 50mgIV	Other: ☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☒ **Ravulizumab-cwvz (Ultomiris)**	300 mg/3 mL OR 1,100 mg/11 mL	☐ **Induction:** mg on day 1 and day 15 ☐ **Maintenance:** mg every 8 weeks (begin 8 weeks after day 15 dose) ☐ **IVIG Supplement:** 600 mg within 4 hours of completing IVIG cycle Infuse in 0.9NS IV for a final concentration of 50mg/ml, infusion rates determined by patient weight in accordance with manufacturer guidelines	☐ # sufficient for dose ☐ 2 vials Refills:

Use current documented weight; round calculated dose to nearest vial size +/- 10% of dose.
If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe the patient for at least 60 minutes after the infusion

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

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

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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Print, complete, and fax completed form to (406) 752-0443

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