



St. Charles Health System

Adult Ambulatory Infusion Order
Ravulizumab-cwvz
(Ultomiris)

Patient Name:
Date of Birth:

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____

Weight: _____ kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE _____**
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. Ravulizumab-cwvz is part of FDA REMS Program
 - a. Providers **MUST** be enrolled in the Ultomiris REMS program. MD **MUST PROVIDE ENROLLMENT ID TO PROCEED:** _____
 - b. Counsel patients using the Ultomiris patient safety card and patient safety brochure. Patients should carry the Ultomiris patient safety card at all times.
 - c. Please see reference links below for enrollment forms and additional help
 - i. <https://ultomirisrems.com/>
 - ii. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Ultomiris_2018_12_21_Prescriber_Enrollment_Form.pdf
 - iii. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Ultomiris_2018_12_21_Prescriber_Safety_Brochure.pdf
 - iv. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Ultomiris_2018_12_21_Patient_Safety_Brochure.pdf
 - v. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Ultomiris_2018_12_21_Patient_Safety_Card.pdf
3. Patients must receive the following meningococcal vaccine at least 2 weeks prior to treatment initiation:
 - a. Meningococcal serogroups A, C, W, Y vaccine (MenACWY) -Menveo, Menactra, or MenQuadfi. These require booster shots every 5 years.
 - b. Meningococcal serogroup B vaccine -Bexsero or Trumenba. These require booster shots 1 year after primary series and every 2 to 3 years thereafter.
 - c. Documentation for vaccines must be sent with the order. Patients not vaccinated should be on prophylaxis antibiotics until vaccines are up to date. Patients who have been vaccinated less than 2 weeks prior to start of infusion should be on 2 weeks of antibacterial prophylaxis.
 - d. Prescriber must update the status of the patient's meningococcal vaccination, indication, and antibacterial drug prophylaxis into the ultsorems.com online portal.



St. Charles Health System

Adult Ambulatory Infusion Order
Ravulizumab-cwvz
(Ultomiris)

Patient Name:

Date of Birth:

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Has this been done? (Yes) (No) – Circle One. If no, you must document the one-time status into the online portal before you may treat the patient.

4. For patients switching from eculizumab to ravulizumab-cwvz, administer ravulizumab-cwvz loading dose 2 weeks after the last eculizumab infusion, and then administer maintenance doses once every 8 weeks, starting 2 weeks after loading dose administration.
5. Closely monitor patients for early signs and symptoms of meningococcal infections and evaluate immediately if infection is suspected. If ravulizumab-cwvz is administered to patients with active systemic infections, monitor for signs and symptoms of worsening infection.
6. Monitor patient after discontinuation for at least 16 weeks for signs and symptoms of hemolysis.
7. Consider penicillin prophylaxis for the duration of ravulizumab-cwvz therapy to potentially reduce the risk of meningococcal disease.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- Meningococcal serogroups A, C, W, Y vaccine (MenACWY) -MenQuadfi, Menactra, or Menveo given on (dates) _____
- Meningococcal serogroup B vaccine (Bexsero or Trumenba) given on (dates) _____

LABS:

- CBC with differential, Routine, ONCE, every visit
- LDH Total, routine, ONCE, every visit
- Labs already drawn. Date: _____

NURSING ORDERS:

1. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and every 15 minutes throughout infusion.
2. Monitor for 1 hour after infusion is complete for signs and symptoms of infusion reaction. Monitoring may be discontinued by provider if no history of prior reaction.
3. Hold treatment and notify provider if patient is not up to date on meningococcal vaccination every 5 years for MenACWY (Menveo, Menactra, or MenQuadfi) or 1 year after primary series and every 2 to 3 years thereafter for MenB (either Bexsero or Trumenba).
4. Administer using a 0.2-micron filter
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, de clotting (alteplase), and/or dressing changes.

MEDICATIONS: Dose is based on weight at time of treatment (must check one)

Loading Dose:

ravulizumab-cwvz (ULTOMIRIS) in sodium chloride 0.9%, intravenous, ONCE, every visit



St. Charles Health System

Adult Ambulatory Infusion Order
Ravulizumab-cwvz
(Ultomiris)

Patient Name:
Date of Birth:

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Patient weight 40-59.9 kg 2400 mg over 60 minutes

Patient weight 60-99.9 kg 2700 mg over 45 minutes

Patient weight 100 kg or greater 3000 mg over 30 minutes

Maintenance Doses:

ravulizumab-cwvz (ULTOMIRIS) in sodium chloride 0.9%, intravenous, ONCE, every visit

Patient weight 40-59.9 kg 3000 mg over 60 minutes

Patient weight 60-99.9 kg 3300 mg over 45 minutes

Patient weight 100 kg or greater 3600 mg over 30 minutes

Interval:

Every 8 weeks beginning 2 weeks after loading dose

Every 8 weeks beginning on date _____

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION



St. Charles Health System

Adult Ambulatory Infusion Order
Ravulizumab-cwvz
(Ultomiris)

Patient Name:
Date of Birth:

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed