Ultomiris (ravulizumab-cwvz)

Provider Order Form rev. 7/20/2022

VASCO INFUSION
www.vascoinfusion.com
ph: 602-346-0204 fax: 877-637-6691

PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)

☐ D59.3 Hemolytic-uremic syndrome

☐ G70.00 Myasthenia Gravis

☐ Other:_____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg / ☐ PO ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mgIV ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) 100mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS

MEDICATION ORDER

Ultomiris (ravulizumab-cwvz)

Dose

Loading Dose (this is a one time dose followed by maintenance dosing):

☐ 600mg IV ☐ 2,400mg IV
☐ 900mg IV ☐ 2,700mg IV
☐ 1,200mg IV ☐ 3,000mg IV

Maintenance Dose:

☐ 300mg IV ☐ 3,000 mg IV
☐ 600mg IV ☐ 3,300 mg IV
☐ 2,100mg IV ☐ 3,600mg IV
☐ 2,700mg IV ☐ Other: _____

Frequency (for maintenance dosing starting 2 weeks after loading dose)

☐ Every 4 weeks
☐ Every 8 weeks
☐ Other:_____

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

Provider Name (Print) **Provider Signature** **Date**

☐ **Check here if this is a stat order**