MHS Home/Alternate Site Infusion Services
Ravulizumab-cwvz (Ultomiris) Infusion Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name:	**DOB:** _____/_____/_____	**Weight:** __________ lb/kg
Patient Phone Number: (______) ______-________	**Requested Date of Service:** _____/_____/_____	
Patient Allergies:		

Diagnosis: ____ **ICD – 10 Code:** ____________________

- Z45.2: Encounter for adjustment and management of vascular access device
- Z95.828: Presence of other vascular implants and grafts

Baseline Labs: none required

Baseline Vaccination Required: Meningococcal vaccine at least 2 weeks prior to administering initial dose of Ravulizumab-cwvz (Ultomiris). Date given: _____/_____/_____

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. ***Patient must be enrolled in Ravulizumab-cwvz (Ultomiris) REMS program before starting.*** **** Emergency phone number for provider _______________________ (required) ****

Provider Order for Ravulizumab-cwvz (Ultomiris) Infusion

ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Biologic Infusion: Infuse via infusion pump via 0.22 micron in-line filter

Ravulizumab-cwvz (Ultomiris) Weight: _______________kg

- ☐ 40 to less than 60 kg: Loading dose = 2400 mg x1; Maintenance dose = 3000 mg every 8 weeks
- ☐ 60 to less than 100 kg: Loading dose = 2700 mg x1; Maintenance dose = 3300 mg every 8 weeks
- ☐ 100 kg or greater: Loading dose = 3000 mg x1; Maintenance dose = 3600 mg every 8 weeks

Loading Dose Infusion Recommendations Using 100 mg/mL (3 mL and 11 mL) vials

Weight (kg)	Loading dose (mg)	Total volume to be administered	Minimum infusion time (hrs)	Maximum infusion rate (mL/hour)
40 to <60 kg	2400 mg	48 mL	0.8 hrs	60 mL/hr
60 to <100 kg	2700 mg	54 mL	0.6 hrs	90 mL/hr
>/=100 kg	3000 mg	60 mL	0.4 hrs	150 mL/hr

Maintenance Dose Infusion Recommendations Using 100 mg/mL (3 mL and 11 mL) vials

Weight (kg)	Loading dose (mg)	Total volume to be administered	Minimum infusion time (hrs)	Maximum infusion rate (mL/hour)
40 to <60 kg	3000 mg	60 mL	0.9 hrs	67 mL/hour
60 to <100 kg	3300 mg	66 mL	0.7 hrs	95 mL/hour
>/=100 kg	3600 mg	72 mL	0.5 hrs	144 mL/hour

Additional Medications for vascular access maintenance:

- 0.9% NaCl (NS) PF flush in 10 mL syringe: Administer 5 – 30 mL IV as needed for establishing and maintaining IV access and for flushing IV line post infusion.
- Heparin: 100 units/mL for port OR 10 units/mL for other central line/midline, 3-5 mL PRN for de-accessing line.
- Cathflo (alteplase) 2 mg: Instill 2 mg (2 mL) into occluded catheter as needed for CVC/CVAD occlusion.

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Patient Identification: Name: MRN: DOB:	Pre-printed order – Page 1 of 2 Ravulizumab-cwvz (Ultomiris) Order Set MultiCare

Skilled Nurse to draw labs as follows:

□ Lab(s): ___________________________________ Frequency: ___________________________________

Skilled Nurse Interventions:

- Admit *(first visit)* patient to services for home infusion therapy of Ravulizumab-cwvz (Ultomiris).
- Complete Skilled Nurse Visit with each infusion for ongoing home infusion therapy of Ravulizumab-cwvz (Ultomiris).
- Obtain vital signs (TPR & B/P) at baseline and completion of infusion.
- Obtain patient weight at each visit.
- Establish IV access and flush per policy to maintain patency.
- Draw labs as ordered.
- Add Ravulizumab-cwvz (Ultomiris) to sodium chloride 0.9% (NS) bag (see page 1 for recommendations)
- Infuse Ravulizumab-cwvz (Ultomiris) as prescribed.
- Once infusion complete, flush IV line with sodium chloride 0.9% (NS) as prescribed.
- If vital signs are stable after infusion, Skilled Nurse will discontinue IV access and complete visit.

If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):

The Skilled Nurse will:

- STOP THE INFUSION.
- Administer emergency medications as prescribed (*below*).
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: □ Yes □ No (if yes, please send DOCUMENTATION of consent with order)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: ___________________________________ **Printed Name:** ________________________________ **Date:** ___________

NPI: _____________________________ Orders expire in 12 months unless otherwise specified: _______________________________

Provider/Clinic Information: Address: ____ Phone #: ____________________ Fax#: ____________________	**Return completed orders to:** MultiCare Home/Alternate Infusion Services 253-459-6650 (phone) / 253-864-2785 (fax)

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Patient Identification: Name: MRN: DOB:	Pre-printed order – Page 2 of 2 Ravulizumab-cwvz (Ultomiris) Order Set MultiCare Revised 06/24