ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

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

Ravulizumab-cwvz (Ultomiris)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis:

- ❑ Atypical Hemolytic Uremic Syndrome (AHUS)
- ❑ Myastheynia gravis (MG)
- ❑ Paroxysmal Nocturnal Hemoglobinuria (PNH)

ICD -10 Code:

- ❑_____
- ❑_____
- ❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline labs required: None required

Maintenance labs: None required ❑ Other_____ ❑ Frequency_____

Baseline Vaccinatin *(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 Eculizumb (Soliris) REMS program before starting.***

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P; Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Pre-meds: Non recommended

Treatment Regimen:
❑ 40 to <60 kg = Loading Dose = 2400 mg x 1; Maintenance Dose = 3000 mg q8 weeks starting 2 weeks after LD
❑ 60 to <100 kg = Loading Dose = 2700 mg x 1; Maintenance Dose = 3300 mg q8 weeks starting 2 weeks after LD
❑ >/= 100 kg = Loading Dose = 3000 mg x 1; Maintenance Dose = 3600 mg q8 weeks starting 2 weeks after LD

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare Hypersensitivity guideline for treatment/management
- Notify provider of reaction, assessment and need for further orders"

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)

Provider Signature	Print Name	Date	Time

Orders expire in 12 months**

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
AHUS / MG / PNH

MultiCare

60-0352-3 (Rev. 9/24)