

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

Lab Orders: _____

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:

- 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.

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FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:

Name:
MRN:
DOB:

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Additional Medications (continued):

- Cathflo (alteplase) 2 mg: Instill 2 mg (2 mL) into occluded catheter as needed for CVC/CVAD occlusion.
- Diphenhydramine 25 mg IV once, as needed for itching.
- Acetaminophen 325-650 mg tab/cap by mouth once, as needed for pain.

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).
- For mild infusion reaction, may restart the infusion at a slower rate (verified with pharmacist) if symptoms resolve with medication.
- 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. Max dose = 50 mg.
- **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 Site Infusion Services
253-459-6650 (phone) / 253-864-2785 (fax)

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:

Name:

MRN:

DOB:

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