RESTORE HEALTH
INFUSION AND WELLNESS

ULTOMIRIS

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Pertinent Labs
(AChR Antibodies, AQP4 Antibodies, MG-ADL Score, Mng Vaccines)

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ D59.32 (aHUS) ☐ D59.5 (PNH) ☐ G36.0 (NMOSD) ☐ G70.00 (MG) ☐ G70.01 (MG)

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

CBC Completed: ☐ Yes ☐ No **CMP/LFTs Completed:** ☐ Yes ☐ No **MG-ADL Score:** _____

REMS Requirements Verified: ☐ Yes ☐ No **Active Meningococcal Infection:** ☐ Yes ☐ No

gMG Diagnosis-ACHR Antibodies: ☐ Yes ☐ No **NMOSD diagnosis-AQP4 Antibodies:** ☐ Yes ☐ No

TREATMENT

ULTOMIRIS(ravulizumab-cwvz)

Route: Intravenous Injection

Dose: ☐ Loading Dose:
- ☐ 40-60kg: 2400mg
- ☐ 60-100kg: 2700mg
- ☐ >100 kg: 3000mg

☐ Maintenance Dose:
- ☐ 40-60kg: 3000mg
- ☐ 60-100kg: 3300mg
- ☐ >100kg: 3600mg

Frequency:
- ☐ Loading Dose: Once
- ☐ Maintenance Dose: Starting 2 weeks after the loading dose and then every 8 weeks therafter

Quantity: _____ **Refills:** _____

Premedication Protocol: *(Not Usually Indicated)*

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

■ *Center will use anaphylactic and hypersensitivity protocol established by Restore Health*

Special Instructions: _____

Provider Signature: _____ Date: _____

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