REVITALIZE
INFUSION CENTER

Ultomiris®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

- ☐ Atypical hemolytic uremic syrndrome (aHUS) ICD-10 Code: D59.3
- ☐ Paroxysmal nocturnal hemoglobinuria (PNH) ICD-10 Code: D59.5
- ☐ Neuromyelitis optica spectrum disorder (NMOSD) ICD-10 Code: G36.0
- ☐ Myasthenia gravis without (acute) exacerbation ICD-10 Code: G70.00
- ☐ Myasthenia gravis with (acute) exacerbation ICD-10 Code: G70.01
- ☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
- Relevant labs and tests
- Required Information:
  - Prescriber is enrolled in REM Program: _____
  - Documentation of meningococcal vaccines
  - Was patient previously on Soliris: ☐ No ☐ Yes. If yes, date of last infusion:_____

Height: _____

Weight: _____

Ultomiris (ravulizumab-cwvz) Orders:

☐ Treatment Initiation: Infuse _____ mg IV initially followed by _____ mg two (2) weeks later to provide two (2) doses

☐ Maintenance Dosing: Infuse _____ mg IV every ☐ four (4) weeks or ☐ eight (8) weeks for one year

☐ Other:_____

Pre-Medication Orders:

Acetaminophen 650 mg PO administered 30 minutes prior to infusion *Adjust PRN

☐ Other:_____

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus