ULTOMIRIS® (RAVULIZUMAB-CWVZ)
Referral Form

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Hy-Vee health INFUSION CARE

Preferred Clinic: ____________________

Patient Information

Referral Status: New Referral Updated Referral Order Renewal

Patient Name: ____________________ **DOB:** __________ **Last 4 Digits SSN:** __________

Patient Address: ____________________ **City/ST/Zip:** ____________________

Patient Phone: __________ **Patient Email:** ____________________

Allergies: ____________________ NKDA **Weight:** ______ lbs kg **Height:** ______ in cm

ICD-10 Code(required): __________ **ICD-10 Code Description:** __________ **Last Treatment Date:** __________

Provider Information

Referral Coordinator Name: ____________________ **Referral Coordinator Email:** ____________________

Ordering Provider: ____________________ **Provider NPI:** ____________________

Referring Practice Name: ____________________ **Phone:** __________ **Fax:** __________

Practice Address: ____________________ **City:** __________ **State:** __________ **Zip Code:** __________

NURSING

☑ Infusion to be administered per Hy-Vee Health Protocols.

LABORATORY ORDERS

CBC At each dose Every ____________________

CMP At each dose Every ____________________

CRP At each dose Every ____________________

Other ____________________

REQUIRED DOCUMENTATION

- Patient Demographics
- Insurance Card/Information
- Progress Notes Supporting DX
- Current Medication List and H&P
- Patient has had the meningococcal vaccines (both MenACWY and MenB)
- Prescriber is enrolled in Ultomiris REMS program

ULTOMIRIS THERAPY ADMINISTRATION

Initial Dosing:

40 kg to 59 kg: 2,400 mg IV loading dose, followed by 3,000 mg IV maintenance 2 weeks later, then 3,000 mg every 8 weeks

60-99 kg: 2,700 mg IV loading dose, followed by 3,300 mg IV maintenance 2 weeks later, then 3,300 mg every 8 weeks

100kg or greater: 3,000mg IV loading dose, followed by 3,600mg IV maintenance 2 weeks later, then 3,600mg IV every 8 weeks

Maintenance Dosing:

40kg to 59kg: 3,000mg IV every 8 weeks

60kg to 99kg: 3,300mg IV every 8 weeks

100kg or greater: 3,600mg IV every 8 weeks

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) ____________________ **Provider Signature** ____________________ **Date** __________

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

HY-VEEHEALTHINFUSION.COM

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