Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Ultomiris (ravulizumab) Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ **Height (inches):** _____ **Weight (lbs):** _____

3. Diagnosis:

[ ] G70.0 Myasthenia Gravis
[ ] Other ICD-10 Code: _____ Diagnosis description: _____

4. Pre-medications:

[ ] Acetaminophen: [ ] **1000mg PO** [ ] **500mg PO**
[ ] Diphenhydramine: [ ] **25mg PO** [ ] **50mg PO** [ ] **25mg IV** [ ] **50mg IV**
[ ] Hydrocortisone: 100mg IVP
[ ] Other Pre-medication: _____
[ ] No Pre-medications indicated

5. Drug Order:

Ultomiris (ravulizumab) *Ok to substitute with generic/biosimilar*

Dose: [ ] **40-60 kg 2,400 mg initial and 3,000 mg maintenance**
[ ] **60-100 kg 2,700 mg initial and 3,300 mg maintenance**
[ ] **over 100 kg 3,000 mg initial and 3,600 mg maintenance**
[ ] Other: _____

Frequency: [ ] **Induction**
[ ] **Maintenance every 8 weeks**
[ ] Other: _____

[ ] New to Therapy
[ ] Continuing Therapy, Last dose received _____ Next dose due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[ ] Other: _____
[ ] No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.
The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. **Required Baseline Lab/Testing completed**:

[ ] CBC & CMP, Date _____ [ ] Meningeal Vaccine: _____ [ ] Other: _____ [ ] None

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

7. **Physician's Name**: _____ **Phone:** _____
Physician's Signature: _____ **Date:** _____

(This drug administration order form is valid for 12 months)