Ultomiris® (ravulizumab-cwvz) Referral Form

BIOHEALTH INFUSION CENTER

www.biohealthic.com | info@biohealthic.com

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

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 BioHealth protocols.

LABORATORY ORDERS

☐ CBC	☐ At each dose	☐ Every _____
☐ CMP	☐ At each dose	☐ Every _____
☐ CRP	☐ At each dose	☐ Every _____
☐ OTHER		

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

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

*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**

Have a Question? (786)460-6044
Fax Referral Form To: (786)219-3917
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