Ravulizumab-cwvz (ULTOMIRIS) Infusion

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Ravulizumab-cwvz is part of FDA REMS Program
    a. Providers MUST be enrolled in the Ultomiris REMS program.
    b. Counsel patients using the Ultomiris patient safety card and patient safety brochure. Patients should carry the Ultomiris patient safety card at all times.
    c. Please see reference links below for enrollment forms and additional help
        i. https://ultomirisrems.com/
        ii. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Ultomiris_2018_12_21_Prescriber_Enrollment_Form.pdf
        iii. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Ultomiris_2018_12_21_Prescriber_Safety_Brochure.pdf
        iv. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Ultomiris_2018_12_21_Patient_Safety_Brochure.pdf
        v. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Ultomiris_2018_12_21_Patient_Safety_Card.pdf
3. Patients must receive the following meningococcal vaccine at least 2 weeks prior to treatment initiation:
    a. Meningococcal serogroups A, C, W, Y vaccine (MenACWY) –Menactra or Menveo. These require booster shots every 5 years.
    Date of last vaccination: _____
    b. Meningococcal serogroup B vaccine –Bexsero or Trumenba. No booster vaccination is required after series is completed once in a lifetime.
    Date of last vaccination: _____

    Documentation for vaccine must be sent with the order.
    Patients not vaccinated should be on prophylaxis antibiotics until vaccines are up to date. Patients who have been vaccinated less than 2 weeks prior to start of infusion should be on 2 weeks of antibacterial prophylaxis.
4. For patients switching from eculizumab to ravulizumab-cwvz, administer ravulizumab-cwvz loading dose 2 weeks after the last eculizumab infusion, and then administer maintenance doses once every 8 weeks, starting 2 weeks after loading dose administration.
5. Closely monitor patients for early signs and symptoms of meningococcal infections and evaluate immediately if infection is suspected. If ravulizumab-cwvz is administered to patients with active systemic infections, monitor for signs and symptoms of worsening infection.
6. Monitor patient after discontinuation for at least 16 weeks for signs and symptoms of hemolysis.
7. Consider penicillin prophylaxis for the duration of ravulizumab-cwvz therapy to potentially reduce the risk of meningococcal disease.

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

☐ Meningococcal polysaccharide vaccines given on (dates) _____

LABS:

☐ CBC with differential, Routine, ONCE, every visit
☐ LDH Total, routine, ONCE, every visit
☐ Labs already drawn. Date: _____

MEDICATION: Dose is based on weight at time of treatment (must check one)

Loading Dose:

ravulizumab-cxvz (ULTOMIRIS) in sodium chloride 0.9%, intravenous, ONCE

Patient weight 40-59.9 kg ☐ **2400 mg over 2 hours**
Patient weight 60-99.9 kg ☐ **2700 mg over 2 hours**
Patient weight 100 kg or greater ☐ **3000 mg over 2 hours**

Maintenance Doses:

ravulizumab-cxvz (ULTOMIRIS) in sodium chloride 0.9%, intravenous, ONCE, every visit

Patient weight 40-59.9 kg ☐ **3000 mg over 2.5 hours**
Patient weight 60-99.9 kg ☐ **3300 mg over 2 hours**
Patient weight 100 kg or greater ☐ **3600 mg over 2.5 hours**

Interval:

☐ Every 8 weeks beginning 2 weeks after loading dose
☐ Every 8 weeks beginning on date _____

NURSING ORDERS:

1. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and every 15 minutes throughout infusion.
2. Observe for 1 hour after infusion complete (Unless the prescriber indicates this is not necessary).
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
4. Hold treatment and notify provider if patient is not up to date on meningococcal vaccination every 5 years for MenACWY (either Menactra or Menveo). Notify provider if vaccines need to be administered.

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Please check the appropriate box for the patient's preferred clinic location:

☐ TUALITY HEALTHCARE
An OHSU Partner

Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ MCMC
MID-COLUMBIA MEDICAL CENTER
A Planetree Patient-Centered Hospital

Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610