Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Ultomiris® (ravulizumab) Infusion Order (Revised 11/10/2025)
All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)
☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ D59.5 - Paroxysmal nocturnal hemoglobinuria	☐ G70.01 - Myastenia Gravis with acute exacerbation
☐ D59.30 - Hemolytic Uremic Syndrome	☐ G70.00 - Myasthenia Gravis without acute exacerbation
☐ Other:	

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion:
Complete Medication List - Include all tried and failed meds	Next infusion due date:
	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Labs:

☑ Urine Pregnancy Test prior to each infusion on all females of reproductive potential
- POC HCG Qualitative, Urine

Treatment Parameters:

☑ Hold treatment and notify provider IF:
- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection.

☑ Required lab results: Urine Pregnancy Test. (**fax labs with order**)
- Hold Tx and Notify Provider IF:
- Urine Pregnancy Test: POSITIVE

Provider Communication:

☑ Ravulizumab is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS). Under the Ultomiris REMS, healthcare providers must enroll in the program. Enrollment in the Ultomiris REMS program and additional information are available from the manufacturer (1-888-765-4747) OR at ultsorems.com

☑ Immunize patients with meningococcal vaccines at least 2 weeks PRIOR to the first dose of ravulizumab, unless the risks of delaying ravulizumab therapy outweigh the risk of developing a meningococcal infection.
If not previously administered give BOTH:
- Quadrivalent meningococcal vaccine (Menveo) IM once
- Meningococcal group B vaccine (Bexsero) IM once
May also consider vaccinations for other encapsulated organisms:
- Haemophilus B conjugate vaccine (ActHIB) IM once
- Pneumococcal vaccine polyvalent (Pneumovax 23) IM once

☑ If meningococcal vaccines administered LESS THAN 2 weeks BEFORE the FIRST dose of ravulizumab, antimicrobial prophylaxis is suggested.

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.
☑ Obtain vital signs PRE-treatment, POST-treatment, and at discharge.
☑ Monitor for signs of reaction or side effects for 60 minutes POST-treatment.

Pre-Medications:

☐ Acetaminophen (Tylenol) 650mg PO ONCE
☐ Diphenhydramine (Benadryl) 25mg PO ONCE
☐ Diphenhydramine (Benadryl) 25mg IV ONCE
☐ Loratadine (Claritin) 10mg PO ONCE
☐ Methylprednisolone Sodium Succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy:

☐ Loading Dose: Ravulizumab (Ultomiris) Week 0

☐ 2400mg (40 - LESS THAN 60kg) IV	☐ 2700mg (60 - LESS THAN 100kg) IV
☐ 3000mg (100kg or more) IV	

☐ Maintenance Dose: Week 2, then every 8 weeks

☐ 3000mg (40 - LESS THAN 60kg) IV	☐ 3300mg (60 - LESS THAN 100kg) IV
☐ 3600mg (100kg or more) IV	

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.
☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.
☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: