6415 Fort Apache Road, Suite #175
Las Vegas, NV 89148
Phone: 702-665-5730
Fax: 702-780-4887

Ultomiris (ravulizumab-cwvz) **Infusion Orders (SQ)**

Patient Name: ____ Date of Birth: ____________________
Address: ____ Phone Number: __________________
Gender: _______ Height: _____ Weight: _____ (lb./kg)

Diagnosis

☐ ____ Paroxysmal Nocturnal Hemoglobinuria
☐ ____ Atypical Hemolytic Uremic Syndrome
☐ ____ Generalized Myasthenia Gravic

Pre-Medication

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125 IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ ________________________
☐ ________________________

Orders

Dosage
☐ 245mg/3.5mL (70mg/mL) Prefilled Syringe (single use) every 8 weeks _________ Refills

Notes

____
____
____
____
____
____
____
____

Ordering Provider

Signature: ____Date: ______________________
Provider:______________________________________ Phone: _________________ Fax: _________________
Address: ____
NPI: ____ DEA: ____