REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET

RAVULIZUMAB (Ultomiris) Infusion Order Form

Original ordering provider must be enrolled in REMS program https://www.ultsolrems.com/ Skowhegan, Maine

Weight: _____kg Height: _____inches [ ] New treatment [ ] Transfer – next due _____

PRIOR TO FIRST DOSE: Verify meningococcal vaccine completed at least 14 days prior to start date.

Note: Do not use combined ABCWY vaccine as full immune effect delayed for 6 months.
**Document dates booster dose due in clinic record.*

- Meningococcal conjugate (MenACWY) vaccine
  0.5 ml IM x 2 doses at least 8 weeks apart **Date complete**_____
  Booster 0.5 ml IM x1 every 5 years.*
- Meningococcal group B (MenB) vaccine
  0.5 ml IM x 2 doses at least 4 weeks apart **Date complete**_____
  Booster 0.5 ml IM once year after series complete, then every 2 to 3 years.*

If less than 2 weeks since full meningococcal vaccination, verify patient is on prophylactic anti-infective for the first 2 weeks of therapy. Consider antimicrobial prophylaxis with oral antibiotics for the duration of therapy.

Antimicrobial therapy ordered if any: _____

PRIOR TO EACH INFUSION: See page 2 for labs, nursing assessment, vital signs, administration and observation times. Pharmacy to verify registration of ordering provider with UltSolREMS.

PRE-MEDICATE (30 minutes before infusion):

[ ] acetaminophen _____ mg PO
[ ] loratadine 10 mg PO
[ ] diphenhydramine _____ mg PO
[ ] methylprednisolone _____ mg IV
[ ] diphenhydramine _____ mg IV

DOSE (select diagnosis and weight range): Administer within 7 days of the recommended interval.
Loading dose(LD) IV once. Maintenance dose (MD) IV every 8 weeks, starting 2 weeks after loading dose.

√	Diagnosis (Check one) Weight:	❑ 20 to <30 kg	❑ 30 to < 40 kg	❑ 40 to < 60 kg	❑ 60 to < 100 kg	❑ ≥100 kgs
	Myasthenia gravis *AChR positive*			LD: 2400 mg then MD: 3000 mg	LD: 2700 mg then MD: 3300 mg	LD: 3000 mg then MD: 3600 mg
	Neuromyelitis optica					
	Atypical hemolytic uremic syndrome	LD: 900 mg then MD: 2100 mg	LD: 1200 mg then MD: 2700 mg			
	Paroxysmal nocturnal hemoglobinuria					

[ ] Other: _____

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Duration of authorization:_____

Checklist for non-RFGH credentialed providers:
[ ] Problem list
[ ] Current medication and allergies attached

FAX RFGH Infusion clinic at 207-858-2404 **Contact Infusion Clinic at 207-858-8722**

Provider signature _____Date_____time_____

Printed name_____ NPI # _____ (**required**)
revised 9/2025

Patient _____

dob_____ phone #_____

PRIOR TO EACH INFUSION:

- Complete Blood Count with Auto Diff (CBC) , Lactic Dehydrogenase (LDH), creatinine (serum), AST, Urinalysis w/Micro/Cult if Indicated.
- Supply patient with the manufacturer/FDA Medication Guide and medication safety card.
- Instruct patient of signs of infusion type reaction and to immediately report chest pain, trouble breathing, or swelling of face, tongue, or throat.
- Assess for infection; delay administration for active infection.

INFUSION

- Will be diluted to 50 mg/ ml in saline.
- Vital signs prior to infusion and every 15 minutes.
- Infuse through a 0.2 or 0.22 micron filter. Flush line with saline after infusion.
- See chart below for maximum infusion rates. Decrease infusion rate for patients experiencing non-allergic infusion reactions. (back pain, muscle spasms, BP changes, rigors, drowsiness.)
- The lower the patient weight, the longer the infusion time that will be required.
- Observe patient for 1 hour after infusion.

Maximum INFUSION RATE:

Weight	Loading dose	Infusion rate	Maintenance dose	Infusion rate
20 to < 30 kg	900 mg	30 mL/hour	2100 mg	30 mL/hour
30 to < 40 kg	1200 mg	48 mL/hour	2700 mg	48 mL/hour
40 to < 60 kg	2400 mg	60 mL/hour	3000 mg	60 mL/hour
60 to < 100 kg	2700 mg	90 mL/hour	3300 mg	90 mL/hour
≤ 100 kg	3000 mg	150 mL/hour	3600 mg	150 mL/hour