

# Ultomiris® (ravulizumab-cwvz) Referral Form



**Preferred Clinic** (select one):

## PATIENT INFORMATION

**Referral Status:**

New Referral

Updated Referral

Referral 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 Digits SSN:

## PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:
Physician Preferred Method of Contact:	Email:	Fax:	Phone:

## NURSING

☒ Infusion to be administered per Vivo protocols.

## LABORATORY ORDERS

<input type="checkbox"/> CBC	at each dose	every _____
<input type="checkbox"/> CMP	at each dose	every _____
<input type="checkbox"/> 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

<b>Patient Demographics</b>	Patient has had the meningococcal vaccines (both MenACWY and MenB)
<b>Insurance Card/Information</b>	
<b>Progress Notes Supporting DX</b>	Prescriber is enrolled in Ultomiris REMS program
<b>Current Medication List and H&amp;P</b>	

\*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
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Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com) OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	

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