BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: _____ Date of Last Infusion: _____
Height _____ Weight _____

Infusion Location: (state and site) _____

Ultomiris (ravulizumab-cwvz) Infusion Orders

Diagnosis-provide ICD-10 code

☐ Myasthenia Gravis (anti-acetylcholine receptor antibody positive)
☐ Other: _____

Nursing Orders:

- Hold infusion for abnormal vital signs or signs/symptoms of infection or Meningitis
- New or worsening headache or altered mental status
- Record vitals before infusion then every 30mins until patient discharges
- If an infusion related reaction occurs, stop infusion and follow hypersensitivity reaction management protocol as clinically indicated
  - Must have meningococcal vaccine at least 2 weeks prior to infusions. If no vaccine, MD must provide 2 weeks of antibacterial drug prophylaxis
  - DO NOT mix 300mg/30ml vials with any other concentrations
  - OK to mix 300mg/3ml and 1100/11ml together if needed

Administer Ultomiris IV

☐	Weight: 40-60kg	☐ Loading: 2400mg (in 24ml NS) then ☐ 2 weeks later 3000mg (in 30ml NS) ☐ Maintenance: 3000mg (in 30ml NS) IV every 8 weeks
☐	Weight: 60-100kg	☐ Loading: 2700mg (in 27ml NS) then ☐ 2 weeks later 3300mg (in 33ml NS) ☐ Maintenance: 3300mg (in 33ml NS) IV every 8 weeks
☐	Weight 100kg or more	☐ Loading: 3000mg (in 30ml NS) then ☐ 2 weeks later 3600mg (in 36ml NS) ☐ Maintenance: 3600mg (in 36ml NS) Iv every 8 weeks
☐	Switching from Eculizumab	☐ Administer loading dose 2 weeks after last dose of eculizumab maintenance infusion. ☐ Then administer maintenance dose of Ultomiris every 8 weeks

- Infuse all doses over 1hour, use a 0.2 micron sterile in-line low protein binding filter.
- If reactions occurs, slow or stop infusion
- Record vital signs prior to discharge
- If patient develops bronchospasm, angioedema, hypotension, urticaria or other signs of anaphylaxis, initiate Hypersensitivity Reaction Management Protocol to include administration of epinephrine 0.3 mg IM STAT

Additional Orders:

_____

_____

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____