KAISER PERMANENTE®

Ravulizumab-cwvz

Atypical Hemolytic Uremic Syndrome

Infusion Therapy Plan Orders

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

Instructions to Provider

Review orders and note any changes. All orders with ☑ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers at the end of this protocol). Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

Please complete all of the following:

☐ **Pre-Service Authorization** has been obtained by Kaiser Permanente **Fax:** 1-888-282-2685 **Voice**: 1-800-289-1363

Order Date: _____ **Weight:** _____kg	**Diagnosis:** ICD-10 code *(REQUIRED):* _____ ICD-10 description _____

General Plan Communication

- This protocol defaults administration in an adult patient with weight greater than or equal to 40 kg. For weights less than 40 kg, drug dose and possibly dosing interval will need to be modified.

Provider Information

- Immunize with first dose of quadrivalent conjugate and serogroup B meningococcal vaccines at least two weeks prior to beginning therapy unless risk of treatment delay outweighs risk of developing meningococcal disease. Recommend antibiotic prophylaxis in consultation with infectious disease specialist to further reduce the risk of invasive meningococcal disease.
- Patient requires 2 injections to complete vaccine series.
- Ravulizumab treatment of aHUS should be a minimum duration of 6 months. Due to heterogeneous nature of aHUS events and patient-specific risk factors, treatment duration beyond the initial 6 months should be individualized.
- Ravulizumab is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).
- Each region must assure that their prescribers are enrolled via https://ultomirisrems.com/ Telephone: 1-888-765-4747
- Verify patient meets criteria for REMs program.
- After discontinuing treatment, closely monitor for at least 16 weeks to detect hemolysis and other reactions.
- For patients switching from eculizumab to ravulizumab, administer the loading dose of ravulizumab 2 weeks after the last eculizumab infusion, and then administer maintenance doses once every 8 weeks starting 2 weeks after loading dose administration.
- Please choose Loading and Maintenance dosing based on patient's **weight**.

Premedications

☐ No default premedications

Medication Guidance: Please choose dosing from Advanced Order Group (AOG) based on patient's **weight**.

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

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Infusion Therapy

***Loading dose*: Orders default to maximum infusion rate per labeling.**

☐ **40 – 59.9 kg:** Ravulizumab-cwvz (ULTOMIRIS) 2,400 mg [**loading**] in 0.9% sodium chloride 48 mL (50 mg/mL) IVPB. Infuse at 64 mL/hr.

☐ **60 – 99.9 kg:** Ravulizumab-cwvz (ULTOMIRIS) 2,700 mg [**loading**] in 0.9% sodium chloride 54 mL (50 mg/mL) IVPB. Infuse at 92 mL/hr.

☐ **100 kg or greater:** Ravulizumab-cwvz (ULTOMIRIS) 3,000 mg [**loading**] in 0.9% sodium chloride 60 mL (50 mg/mL) IVPB. Infuse at 144 mL/hr.

Route: **Intravenous**
Frequency: **Once**

***Maintenance dose (Due 14 days after Loading dose, then Q56 days)*:**
Orders default to maximum infusion rate per labeling.

☐ **40 – 59.9 kg:** Ravulizumab-cwvz (ULTOMIRIS) 3,000 mg [**maintenance**] in 0.9% sodium chloride 60 mL (50 mg/mL) IVPB. Infuse at 65 mL/hr.

☐ **60 – 99.9 kg:** Ravulizumab-cwvz (ULTOMIRIS) 3,300 mg [**maintenance**] in 0.9% sodium chloride 66 mL (50 mg/mL) IVPB. Infuse at 99 mL/hr.

☐ **100 kg or greater:** Ravulizumab-cwvz (ULTOMIRIS) 3,600 mg [**maintenance**] in 0.9% sodium chloride 72 mL (50 mg/mL) IVPB. Infuse at 144 mL/hr.

Route: **Intravenous**
Frequency: **Q56 days**

IV Line Care

☑ 0.9% sodium chloride infusion 250 mL
Rate: 30 mL/hr *Route:* Intravenous *Frequency:* Run continuously to keep vein open
Start peripheral IV if no central line

Infusion Reaction Meds

☑ albuterol (PROVENTIL) nebulizer solution 0.083%
Dose: 2.5 mg *Route:* Nebulization *Frequency:* PRN for shortness of breath/wheezing

☑ diphenhydrAMINE (BENADRYL) injectable
Dose: 25 mg *Route:* Intravenous *Frequency:* Once PRN, May repeat x1 for urticaria, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

☑ EPINEPHrine (EpiPen) 0.3 mg/0.3 mL IM Auto-Injector
Dose: 0.3 mg *Route:* Intramuscular *Frequency:* Once PRN for anaphylaxis. Inject into lateral thigh and hold for 10 seconds. Massage the injected area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5 inch needle for patients with BMI greater than 30. Notify physician if administered.

☑ hydrocortisone sodium succinate (SOLU-CORTEF) injectable
Dose: 100 mg *Route:* Intravenous *Frequency:* Once PRN for hypersensitivity

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

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Lab Review for Nursing

- Baseline labs: CBC with Diff, CMP, LDH
- Labs before treatment: No default labs
- ** Intermittent Labs: After ravulizumab discontinuation for aHUS, monitor CBC, SCr, LDH for at least 12 months

Nursing Orders

BEFORE first infusion:

- Verify that meningococcal vaccine has been given and documented.
- Immunize with first dose of quadrivalent conjugate and serogroup B meningococcal vaccines at least two weeks prior to beginning therapy unless risk of treatment delay outweighs risk of developing meningococcal disease. Patient requires 2 injections to complete vaccine series.

ADMINISTRATION:

- Verify that patient meets the lab parameters for administration.
- Perform assessment for toxicity and tolerance.
- Attach a 0.2 or 0.22 micron low protein binding filter for administration.
- Infusion-related reactions, STOP infusion immediately, and begin primary solution at wide open rate, notify MD, begin monitoring vital signs and administer prn medication for infusion reaction; Consult with MD prior to restarting medication.
- Monitor the patient for at least one hour following completion of the infusion for signs or symptoms of an infusion reaction.

References

Ultomiris Package insert

Kaiser Permanente Infusion Locations

Bellevue Medical Center
11511 NE 10th St, Bellevue, WA 98004
Fax: 425-502-3512 Phone: 425-502-3510

Capitol Hill Medical Center
201 16th Ave E, Seattle WA 98112
Fax: 206-326-2104 Phone: 206-326-3109

Everett Medical Center
2930 Maple St, Everett, WA 98201
Fax: 425-261-1578 Phone: 425-261-1566

Olympia Medical Center
700 Lilly Road N.E., Olympia, WA 98506
Fax: 360-923-7106 Phone: 360-923-7164

Riverfront Medical Center – Spokane
W 322 North River Drive, Spokane, WA 99201
Fax: 509-324-7168 Phone: 509-241-2073

Silverdale Medical Center
10452 Silverdale Way NW, Silverdale, WA 98383
Fax: 360-307-7421 Phone: 360-307-7316

Tacoma Medical Center
209 Martin Luther King Jr Way, Tacoma, WA 98405
Fax: 253-383-6262 Phone: 253-596-3666

Provider Signature: _____ **Date:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____