

**Ravulizumab-cwvz**  
**Paroxysmal Nocturnal Hemoglobinuria**  
**Infusion Therapy Plan Orders**

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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

<b>Order Date:</b> _____  <b>Weight:</b> _____ kg	<b>Diagnosis:</b> ICD-10 code ( <i>REQUIRED</i> ): _____  ICD-10 description _____ _____
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**General Plan Communication**

- 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.

**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/Consider 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 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.
- Please choose Loading and Maintenance dosing based on patient's **weight**.

**Premedications**

- No default premedications

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

**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.

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

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- 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 PNH, monitor LDH for at least 16 weeks

**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 10<sup>th</sup> St, Bellevue, WA 98004

Fax: 425-502-3512 Phone: 425-502-3510

**Capitol Hill Medical Center**

201 16<sup>th</sup> 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: \_\_\_\_\_