ULTOMIRIS® (ravulizumab-cwvz)
injection for intravenous use
300 mg/3 mL vial

Pocket Dosing Guide

- ULTOMIRIS 100 mg/mL is an advanced formulation of ULTOMIRIS to provide a quicker infusion time for your patients every 4 or 8 weeks, depending on body weight
- ULTOMIRIS 100 mg/mL has a safety and efficacy profile that is consistent with ULTOMIRIS 10 mg/mL
- The ULTOMIRIS 10 mg/mL formulation will be phased out in mid-2021 and replaced by the ULTOMIRIS 100 mg/mL vials

INDICATIONS

Paroxysmal Nocturnal Hemoglobinuria (PNH)
ULTOMIRIS is indicated for the treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH).

Atypical Hemolytic Uremic Syndrome (aHUS)
ULTOMIRIS is indicated for the treatment of adults and pediatric patients one month of age and older with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA).

Limitation of Use:
ULTOMIRIS is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).

SELECT IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS MENINGOCOCCAL INFECTIONS
Life-threatening meningococcal infections/sepsis have occurred in patients treated with ULTOMIRIS. Meningococcal infection may become rapidly life-threatening or fatal if not recognized and treated early.
- Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccination in patients with complement deficiencies.
- Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first dose of ULTOMIRIS, unless the risks of delaying ULTOMIRIS therapy outweigh the risk of developing a meningococcal infection. See Warnings and Precautions for additional guidance on the management of the risk of meningococcal infection.
- Vaccination reduces, but does not eliminate, the risk of meningococcal infections. Monitor patients for early signs of meningococcal infections and evaluate immediately if infection is suspected.

ULTOMIRIS is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS). Under the ULTOMIRIS REMS, prescribers must enroll in the program. Enrollment in the ULTOMIRIS REMS program and additional information are available by telephone: 1-888-765-4747 or at www.ultomirisrems.com.

Please see additional Important Safety Information throughout and accompanying full Prescribing Information for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections/sepsis.
ULTOMIRIS is administered once every 8 weeks in adults or once every 4-8 weeks in pediatric patients (depending on body weight).

**ULTOMIRIS WEIGHT-BASED DOSING REGIMEN**

<table>
<thead>
<tr>
<th>Body Weight Range (kg)</th>
<th>Loading Dose (mg)</th>
<th>Maintenance Dose (mg) and Dosing Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 to &lt; 60</td>
<td>2,400</td>
<td>3,000, Every 8 weeks</td>
</tr>
<tr>
<td>60 to &lt; 100</td>
<td>2,700</td>
<td>3,300, Every 8 weeks</td>
</tr>
<tr>
<td>100 or greater</td>
<td>3,000</td>
<td>3,600, Every 8 weeks</td>
</tr>
</tbody>
</table>

For adult patients with PNH and patients with atypical-HUS

**Dosing considerations**

- Administration of PE/PI (plasmapheresis or plasma exchange, or fresh frozen plasma infusion) may reduce ULTOMIRIS serum levels. There is no experience with administration of supplemental doses of ULTOMIRIS.
- The dosing schedule is allowed to occasionally vary within 7 days of the scheduled infusion day (except for the first maintenance dose of ULTOMIRIS), but the subsequent doses should be administered according to the original schedule.

For adult patients weighing ≥40 kg

**ULTOMIRIS is administered once every 8 weeks**

The recommended dosing regimen consists of a loading dose followed by maintenance doses.

**ADULT PATIENTS STARTING ULTOMIRIS WITH NO PRIOR TREATMENT**

Starting 2 weeks after the initial loading dose, maintenance doses are administered once every 8 weeks.

**ADULT PATIENTS SWITCHING FROM ECULIZUMAB TO ULTOMIRIS**

Loading dose of ULTOMIRIS should be administered 2 weeks after the last eculizumab infusion. Maintenance doses are administered once every 8 weeks, starting 2 weeks after the loading dose.

For adult patients with atypical-HUS

**ULTOMIRIS is administered based on weight**

**ULTOMIRIS WEIGHT-BASED DOSING REGIMEN**

<table>
<thead>
<tr>
<th>Body Weight Range (kg)</th>
<th>Loading Dose (mg)</th>
<th>Maintenance Dose (mg) and Dosing Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to &lt; 10</td>
<td>600</td>
<td>300, Every 4 weeks</td>
</tr>
<tr>
<td>10 to &lt; 20</td>
<td>600</td>
<td>600, Every 4 weeks</td>
</tr>
<tr>
<td>20 to &lt; 30</td>
<td>900</td>
<td>2,100, Every 8 weeks</td>
</tr>
<tr>
<td>30 to &lt; 40</td>
<td>1,200</td>
<td>2,700, Every 8 weeks</td>
</tr>
<tr>
<td>40 to &lt; 60</td>
<td>2,400</td>
<td>3,000, Every 8 weeks</td>
</tr>
<tr>
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<tr>
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<td>3,600, Every 8 weeks</td>
</tr>
</tbody>
</table>

For adult patients with PNH weighing ≥40 kg

**ULTOMIRIS is administered once every 8 weeks**

The recommended dosing regimen consists of a loading dose followed by maintenance doses.

**ADULT PATIENTS STARTING ULTOMIRIS WITH NO PRIOR TREATMENT**

Starting 2 weeks after the initial loading dose, maintenance doses are administered once every 8 weeks.

**ADULT PATIENTS SWITCHING FROM ECULIZUMAB TO ULTOMIRIS**

Loading dose of ULTOMIRIS should be administered 2 weeks after the last eculizumab infusion. Maintenance doses are administered once every 8 weeks, starting 2 weeks after the loading dose.

For patients with atypical-HUS

**ULTOMIRIS is administered once every 8 weeks in adults or once every 4-8 weeks in pediatric patients (depending on body weight)**

**THE RECOMMENDED DOSING REGIMEN CONSISTS OF A LOADING DOSE FOLLOWED BY MAINTENANCE DOSES**

**ADULT PATIENTS WITH ATYPICAL-HUS**

Starting 2 weeks after the initial loading dose, maintenance doses are administered once every 8 weeks.

**PEDIATRIC PATIENTS ≥1 MONTH OF AGE WITH ATYPICAL-HUS WEIGHING ≥5 KG**

Starting 2 weeks after the initial loading dose, maintenance doses are administered once every 8 weeks or every 4 weeks depending on body weight.

For adult and pediatric patients with atypical-HUS transitioning from eculizumab to ULTOMIRIS

- Loading dose of ULTOMIRIS should be administered 2 weeks after the last eculizumab infusion.
- Maintenance doses are administered once every 8 weeks or every 4 weeks (depending on body weight), starting 2 weeks after the loading dose.

For patients with atypical-HUS

**ULTOMIRIS is administered based on weight**

**ULTOMIRIS WEIGHT-BASED DOSING REGIMEN**

<table>
<thead>
<tr>
<th>Body Weight Range (kg)</th>
<th>Loading Dose (mg)</th>
<th>Maintenance Dose (mg) and Dosing Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to &lt; 10</td>
<td>600</td>
<td>300, Every 4 weeks</td>
</tr>
<tr>
<td>10 to &lt; 20</td>
<td>600</td>
<td>600, Every 4 weeks</td>
</tr>
<tr>
<td>20 to &lt; 30</td>
<td>900</td>
<td>2,100, Every 8 weeks</td>
</tr>
<tr>
<td>30 to &lt; 40</td>
<td>1,200</td>
<td>2,700, Every 8 weeks</td>
</tr>
<tr>
<td>40 to &lt; 60</td>
<td>2,400</td>
<td>3,000, Every 8 weeks</td>
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<tr>
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<td>3,300, Every 8 weeks</td>
</tr>
<tr>
<td>100 or greater</td>
<td>3,000</td>
<td>3,600, Every 8 weeks</td>
</tr>
</tbody>
</table>
Infusing adult patients with PNH and patients with atypical-HUS

The ULTOMIRIS 10 mg/mL formulation will be phased out in mid-2021 and replaced by the ULTOMIRIS 100 mg/mL vials. The crossover period from ULTOMIRIS 10 mg/mL to ULTOMIRIS 100 mg/mL is provided to ensure there is no interruption to product availability, allowing continuation of your patient’s infusion schedule.

### ULTOMIRIS WEIGHT-BASED DOSING: 10 mg/mL FORMULATION

<table>
<thead>
<tr>
<th>Body weight rangea (kg)</th>
<th>ULTOMIRIS volume</th>
<th>Volume of 0.9% NaClb</th>
<th>Total Volume (dose)</th>
<th>Minimum infusion time (hr)</th>
<th>Maximum infusion rate (mL/hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to &lt;10</td>
<td>60 mL</td>
<td>60 mL</td>
<td>120 mL</td>
<td>3.8</td>
<td>31</td>
</tr>
<tr>
<td>10 to &lt;20</td>
<td>60 mL</td>
<td>60 mL</td>
<td>120 mL</td>
<td>1.9</td>
<td>63</td>
</tr>
<tr>
<td>20 to &lt;30</td>
<td>90 mL</td>
<td>90 mL</td>
<td>180 mL</td>
<td>1.5</td>
<td>120</td>
</tr>
<tr>
<td>30 to &lt;40</td>
<td>120 mL</td>
<td>120 mL</td>
<td>240 mL</td>
<td>1.3</td>
<td>184</td>
</tr>
<tr>
<td>40 to &lt;60</td>
<td>240 mL</td>
<td>240 mL</td>
<td>480 mL</td>
<td>1.9</td>
<td>252</td>
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<tr>
<td>60 to &lt;100</td>
<td>270 mL</td>
<td>270 mL</td>
<td>540 mL</td>
<td>1.7</td>
<td>317</td>
</tr>
<tr>
<td>100 or greater</td>
<td>300 mL</td>
<td>300 mL</td>
<td>600 mL</td>
<td>1.8</td>
<td>333</td>
</tr>
</tbody>
</table>

*Loading dose administration*

*Maintenance dose administration*

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### ULTOMIRIS WEIGHT-BASED DOSING: 100 mg/mL FORMULATION

<table>
<thead>
<tr>
<th>Body weight rangea (kg)</th>
<th>ULTOMIRIS volume</th>
<th>Volume of 0.9% NaClb</th>
<th>Total Volume (dose)</th>
<th>Minimum infusion time (hr)</th>
<th>Maximum infusion rate (mL/hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to &lt;10</td>
<td>6 mL</td>
<td>6 mL</td>
<td>12 mL</td>
<td>1.4</td>
<td>8</td>
</tr>
<tr>
<td>10 to &lt;20</td>
<td>6 mL</td>
<td>6 mL</td>
<td>12 mL</td>
<td>0.8</td>
<td>16</td>
</tr>
<tr>
<td>20 to &lt;30</td>
<td>9 mL</td>
<td>9 mL</td>
<td>18 mL</td>
<td>0.6</td>
<td>30</td>
</tr>
<tr>
<td>30 to &lt;40</td>
<td>12 mL</td>
<td>12 mL</td>
<td>24 mL</td>
<td>0.5</td>
<td>46</td>
</tr>
<tr>
<td>40 to &lt;60</td>
<td>24 mL</td>
<td>24 mL</td>
<td>48 mL</td>
<td>0.8</td>
<td>64</td>
</tr>
<tr>
<td>60 to &lt;100</td>
<td>27 mL</td>
<td>27 mL</td>
<td>54 mL</td>
<td>0.6</td>
<td>92</td>
</tr>
<tr>
<td>100 or greater</td>
<td>30 mL</td>
<td>30 mL</td>
<td>60 mL</td>
<td>0.4</td>
<td>144</td>
</tr>
</tbody>
</table>

*Loading dose administration*

*Maintenance dose administration*

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*Body weight at time of treatment.*

* Dilute ULTOMIRIS only using 0.9% Sodium Chloride Injection, USP.

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Please see additional important safety information throughout and accompanying full prescribing information for ULTOMIRIS, including boxed warning regarding serious and life-threatening meningococcal infections/sepsis.
**ULTOMIRIS 10 mg/mL**

**Ordering vials for adult patients with PNH and patients with atypical-HUS**

The ULTOMIRIS 10 mg/mL formulation comes in 1 single-dose vial, 300 mg/30 mL (blue cap), and is a clear to translucent, slight whitish color.

<table>
<thead>
<tr>
<th>Body weight range (kg)</th>
<th>ULTOMIRIS volume</th>
<th>ULTOMIRIS 10 mg/mL vials</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to &lt; 10</td>
<td>60 mL</td>
<td>2</td>
</tr>
<tr>
<td>10 to &lt; 20</td>
<td>60 mL</td>
<td>2</td>
</tr>
<tr>
<td>20 to &lt; 30</td>
<td>90 mL</td>
<td>3</td>
</tr>
<tr>
<td>30 to &lt; 40</td>
<td>120 mL</td>
<td>4</td>
</tr>
<tr>
<td>40 to &lt; 60</td>
<td>240 mL</td>
<td>8</td>
</tr>
<tr>
<td>60 to &lt; 100</td>
<td>270 mL</td>
<td>9</td>
</tr>
<tr>
<td>100 or greater</td>
<td>300 mL</td>
<td>10</td>
</tr>
</tbody>
</table>

**Loading dose administration**

**Maintenance dose administration**

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**ULTOMIRIS 100 mg/mL**

**Ordering vials for adult patients with PNH and patients with atypical-HUS**

The ULTOMIRIS 100 mg/mL formulation comes in 2 single-dose vials, 1,100 mg/11 mL (aqua cap) and 300 mg/3 mL (lavender cap), and is a translucent, clear to yellowish color. With ULTOMIRIS 100 mg/mL, there is an optimal vial mix (3 mL and 11 mL) for each patient weight cohort, ensuring there is no product wastage.

<table>
<thead>
<tr>
<th>Body weight range (kg)</th>
<th>ULTOMIRIS volume</th>
<th>ULTOMIRIS 100 mg/mL vial combinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to &lt; 10</td>
<td>6 mL</td>
<td>1,100 mg/11 mL 300 mg/3 mL 2</td>
</tr>
<tr>
<td>10 to &lt; 20</td>
<td>6 mL</td>
<td>1,100 mg/11 mL 300 mg/3 mL 2</td>
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<td>1,100 mg/11 mL 300 mg/3 mL 8</td>
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<tr>
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</tr>
<tr>
<td>100 or greater</td>
<td>30 mL</td>
<td>1,100 mg/11 mL 300 mg/3 mL 10</td>
</tr>
</tbody>
</table>

**Loading dose administration**

**Maintenance dose administration**

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Please see additional Important Safety Information throughout and accompanying full Prescribing Information for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections/sepsis.
Preparing and administering ULTOMIRIS

1. Weigh patient

2. Determine how many ULTOMIRIS vials are needed based on patient weight, prescribed dose, and dosage form and strength (see pages 4-7 for reference)
   - Vials should be stored at refrigeration (2°-8°C, 36°-46°F), protected from light
   - Each vial of ULTOMIRIS is intended for single-dose only

3. Allow ULTOMIRIS vials to come to room temperature (18°-25°C, 64°-77°F) naturally without using any heat source

4. Visually inspect each ULTOMIRIS vial to be sure there is no particulate or precipitate (if either, do not use)

5. Using aseptic technique, withdraw the volume of ULTOMIRIS (corresponding to the prescribed dose) from the appropriate number of vials and add to an equal volume (1:1) of 0.9% Sodium Chloride Injection, USP, in an infusion bag (see pages 4-7 for reference)
   - ULTOMIRIS is supplied in three single-dose vials (300 mg/30 mL, 1,100 mg/11 mL, and 300 mg/3 mL) to enable an optimal vial mix for each weight cohort, ensuring there is no product wastage
   - ULTOMIRIS 100 mg/mL (3 mL and 11 mL) and 10 mg/mL (30 mL) vials should not be mixed together
   - ULTOMIRIS requires dilution to a final concentration of 50 mg/mL for the 3 mL and 11 mL vials or a final concentration of 5 mg/mL for the 30 mL vials

Preparing and administering ULTOMIRIS (cont)

6. Gently mix the solution by swirling (do not shake or introduce air bubbles)

7. Administer the solution immediately to the patient through a 0.2 or 0.22 micron filter
   - If the solution is not administered immediately, the solution can be stored at refrigeration (2°-8°C, 36°-46°F) for ≤24 hours, taking into account the expected infusion time. Do not freeze the solution
   - When administering stored (refrigerated) solution, be sure to bring to room temperature naturally before administering, and be sure to administer within 6 hours if prepared with ULTOMIRIS 30 mL vials or within 4 hours if prepared with ULTOMIRIS 3 mL or 11 mL vials

8. The length of infusion time will vary based on the dose as determined by the patient’s weight, but the rate of infusion should not exceed the maximum for each dose (see pages 4-7 for reference)

9. Monitor patient for 1 hour following infusion to ensure no signs or symptoms of an infusion-related reaction occur
   - If an adverse reaction occurs during the administration of ULTOMIRIS, the infusion may be slowed or stopped at the discretion of the physician. Interrupt ULTOMIRIS infusion and institute appropriate supportive measures if signs of cardiovascular instability or respiratory compromise occur
   - Some signs of infusion-related reaction include: lower back pain, drop in blood pressure, infusion-related pain, elevation in blood pressure, and limb discomfort
SELECT IMPORTANT SAFETY INFORMATION (cont)

CONTRAINDICATIONS

- Patients with unresolved Neisseria meningitidis infection.
- Patients who are not currently vaccinated against Neisseria meningitidis, unless the risks of delaying ULTOMIRIS treatment outweigh the risks of developing a meningococcal infection.

WARNINGS AND PRECAUTIONS

Serious Meningococcal Infections

Risk and Prevention

Life-threatening meningococcal infections have occurred in patients treated with ULTOMIRIS. The use of ULTOMIRIS increases a patient’s susceptibility to serious meningococcal infections (sepsisemia and/or meningitis). Meningococcal disease due to any serogroup may occur.

Vaccinate or revaccinate for meningococcal disease according to the most current ACIP recommendations for patients with complement deficiencies. Immunize patients without a history of meningococcal vaccination at least 2 weeks prior to the first dose of ULTOMIRIS. If ULTOMIRIS must be initiated immediately in an unvaccinated patient, administer meningococcal vaccine(s) as soon as possible and provide 2 weeks of antibacterial drug prophylaxis. In clinical studies, 59 patients with PNH were treated with ULTOMIRIS less than 2 weeks after meningococcal vaccination. All of these patients received antibiotics for prophylaxis of meningococcal infection until at least 2 weeks after meningococcal vaccination. The benefits and risks of antibiotic prophylaxis for prevention of meningococcal infections in patients receiving ULTOMIRIS have not been established. In PNH clinical studies, 3 out of 261 PNH patients developed serious meningococcal infections/sepsis while receiving treatment with ULTOMIRIS; all 3 had been vaccinated. These 3 patients recovered while continuing treatment with ULTOMIRIS. Consider discontinuation of ULTOMIRIS in patients who are undergoing treatment for serious meningococcal infection.

REMS

Under the ULTOMIRIS REMS, prescribers must enroll in the program due to the risk of meningococcal infections. Prescribers must counsel patients about the risk of meningococcal infection/sepsis, provide the patients with the REMS educational materials, and ensure patients are vaccinated with meningococcal vaccines.

Other Infections

Patients may have increased susceptibility to encapsulated bacteria infections, especially infections caused by Neisseria meningitidis but also Streptococcus pneumoniae, Haemophilus influenzae, and to a lesser extent, Neisseria gonorrhoeae. Children treated with ULTOMIRIS may be at increased risk of developing serious infections due to Streptococcus pneumoniae and Haemophilus influenzae type b (Hib). Administer vaccinations for the prevention of Streptococcus pneumoniae and Haemophilus influenzae type b (Hib) infections according to ACIP guidelines. If ULTOMIRIS is administered to patients with active systemic infections, monitor closely for worsening infection.

Monitoring Disease Manifestations after ULTOMIRIS Discontinuation

Treatment Discontinuation for PNH

After discontinuing treatment with ULTOMIRIS, closely monitor for signs and symptoms of hemolysis, identified by elevated LDH along with sudden decrease in PNH clone size or hemoglobin, or re-appearance of symptoms such as fatigue, hemoglobinuria, abdominal pain, shortness of breath (dyspnea), major adverse vascular event (including thrombosis), dysphagia, or erectile dysfunction. Monitor any patient who discontinues ULTOMIRIS for at least 16 weeks to detect hemolysis and other reactions. If signs and symptoms of hemolysis occur after discontinuation, including elevated LDH, consider restarting treatment with ULTOMIRIS.

Please see additional Important Safety Information throughout and accompanying full Prescribing Information for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections/sepsis.

SELECT IMPORTANT SAFETY INFORMATION (cont)

Treatment Discontinuation for aHUS

ULTOMIRIS 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. There are no specific data on ULTOMIRIS discontinuation. After discontinuing treatment with ULTOMIRIS, patients should be monitored for clinical symptoms and laboratory signs of TMA complications for at least 12 months.

TMA complications post-discontinuation can be identified if any of the following is observed: Clinical symptoms of TMA include changes in mental status, seizures, angina, dyspnea, thrombosis or increasing blood pressure. In addition, at least two of the following laboratory signs observed concurrently and results should be confirmed by a second measurement: a decrease in platelet count of 25% or more as compared to either baseline or to peak platelet count during ULTOMIRIS treatment; an increase in serum creatinine of 25% or more as compared to baseline or to nadir during ULTOMIRIS treatment; or, an increase in serum LDH of 25% or more as compared to baseline or to nadir during ULTOMIRIS treatment. If TMA complications occur after discontinuation, consider reinitiation of ULTOMIRIS treatment or appropriate organ-specific supportive measures.

Thromboembolic Event Management

The efficacy of withdrawal of anticoagulant therapy during treatment with ULTOMIRIS has not been established. Treatment should not alter anticoagulant management.

Infusion-Related Reactions

Administration of ULTOMIRIS may result in infusion-related reactions. In clinical trials, 5 out of 296 patients treated with ULTOMIRIS experienced infusion-related reactions (lower back pain, drop in blood pressure, infusion-related pain, elevation in blood pressure and limbs discomfort) during ULTOMIRIS administration which did not require discontinuation. Interrupt infusion and institute supportive measures if signs of cardiovascular instability or respiratory compromise occur.

ADVERSE REACTIONS

Adverse Reactions for PNH

Adverse reactions reported in 5% or more of patients treated with ULTOMIRIS vs. Eculizumab was Upper respiratory tract infection (39% vs 39%), Headache (32% vs. 26%), Diarrhea (9% vs. 9%), Nausea (9% vs. 8%), Pyrexia (7% vs 8%), Pain in extremity (6% vs. 5%), Abdominal pain (6% vs. 7%), Dizziness (5% vs. 6%), Arthralgia (5% vs. 5%).

Serious adverse reactions were reported in 15 (6.8%) patients receiving ULTOMIRIS. The serious adverse reactions in patients treated with ULTOMIRIS included hyperthermia and pyrexia. No serious adverse reaction was reported in more than 1 patient treated with ULTOMIRIS.

One fatal case of sepsis was identified in a patient treated with ULTOMIRIS.

Adverse Reactions for aHUS

Most common adverse reactions in patients with aHUS (incidence ≥20%) were upper respiratory tract infection, diarrhea, nausea, vomiting, headache, hypertension and pyrexia. Serious adverse reactions were reported in 42 (57%) patients with aHUS receiving ULTOMIRIS. The most frequent serious adverse reactions reported in more than 2 patients (2.7%) treated with ULTOMIRIS were hypertension, pneumonia and abdominal pain. In clinical studies, clinically relevant adverse reactions in <10% of patients include viral tonsillitis in adults and viral infection in pediatric patients.

Please see additional Important Safety Information throughout and accompanying full Prescribing Information for ULTOMIRIS, including Boxed WARNING regarding serious and life-threatening meningococcal infections/sepsis.

REFERENCE


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ULTOMIRIS 100 mg/mL

- Is an advanced formulation of ULTOMIRIS to provide a quicker infusion time for your patients every 4 or 8 weeks, depending on body weight

- Reduces each maintenance infusion by more than 60 minutes compared to ULTOMIRIS 10 mg/mL, giving your patients back more time to do what they love

- Also reduces the number of vials to store and prepare for the majority of patients’ infusions, allowing more time to focus on the patient

- Has the same mechanism of action as ULTOMIRIS 10 mg/mL

- Has a safety and efficacy profile that is consistent with ULTOMIRIS 10 mg/mL

- Offers a reduced infusion volume compared with ULTOMIRIS 10 mg/mL and SOLIRIS® (eculizumab), easing concerns of infusions in patients who are sensitive to fluid overload