

Soliris (Eculizumab)

PATIENT INFORMATION

Referral Status (check one): New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight _____ Please specify: lbs kg Height: _____

Patient Status (check one): New to Therapy Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

Monitor the patient for at least one hour following completion of the infusion for signs or symptoms of an infusion reaction.

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg | 650mg | 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg | 50mg | PO | IV
- methylprednisolone (Solu-Medrol) 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
- Dose: _____ Route: _____
- Frequency: _____

THERAPY ADMINISTRATION

- Eculizumab** (Soliris) in 0.9% sodium chloride, IV infusion
 - **Dose: Induction:** (Choose one. If patient has already completed induction dose, proceed to maintenance dose.)
 - 600mg weekly for the first four weeks followed by 900mg for the fifth dose one week later, then 900mg two weeks later
 - 900mg weekly for the first four weeks followed by 1200mg for the fifth dose one week later, then 1200mg two weeks later
 - **Dose: Maintenance:** (Choose one)
 - 900mg every two weeks / 1200mg every two weeks
 - Dilute with 0.9% NS to a final concentration of 5mg/ml. (300mg doses final volume 60ml, 600mg doses final volume 120ml, 900mg doses final volume 180ml, 1200mg doses final volume 240ml.)
 - Infuse over 35 minutes in adults and 1-4 hours in pediatric patients
- Flush with 0.9% sodium chloride at infusion completion
- Patient is required to stay for 60 min. observation
- Refills: Zero / for 12 months / _____
 (if not indicated order will expire one year from date signed)

Please continue to next page.

____ / ____ / ____
Today's Date

Patient Name (Print)

____ / ____ / ____
DOB

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

Provider Name (Print) Provider Signature Date