ECULIZUMAB (SOLIRIS®) PRESCRIBER ORDER FORM

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
Meningococcal Vaccination Status:	☐ Primary vaccination series completed – date: _____ ☐ MenACWY booster completed – date: _____ ☐ MenB booster completed – date: _____

Eculizumab (Soliris®) Prescription

Eculizumab (Soliris®) refill as directed x 1 year

Induction Dose:
- ☐ Infuse 600 mg IV over at least 35 min weekly x 4 weeks.
- ☐ Infuse 900 mg IV over at least 35 min weekly x 4 weeks.
- ☐ Other: _____

Maintenance Dose:
- ☐ Infuse 900 mg IV over at least 35 min on Week 5, then every 2 weeks thereafter.
- ☐ Infuse 1200 mg IV over at least 35 min on Week 5, then every 2 weeks thereafter.
- ☐ Infuse _____ mg IV over at least 35 min every 2 weeks.
- ☐ Other: _____

Max infusion time not to exceed 2 hours.

Ancillary Orders

Anaphylaxis Kit

If this is a first dose, does this patient require an anaphylaxis kit?

☐ Yes, with 1st dose ☐ Yes, with all doses

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders
- ☐ Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.
- ☐ Other: _____

IV Flush Orders
- ☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- ☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders
- ☐ No labs ordered at this time.
- ☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to:

