ECULIZUMAB (SOLIRIS®) PRESCRIBER ORDER FORM

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

option care health

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 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?
☐ Yes – please complete Anaphylaxis Physician Order (FR-PC-036) ☐ No

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: NS 2 to 3 mL pre-/post-use.
☐ Implanted Port: NS 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:**

