

# ECULIZUMAB (SOLIRIS®) PRESCRIBER ORDER FORM

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



<b>Patient Name:</b>	<b>Date of Birth:</b>			
<b>Address:</b>				
<b>Phone:</b>	<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b>	<input type="checkbox"/> lbs <input type="checkbox"/> kg

## Clinical Information

<b>Primary Diagnosis Description:</b>	<b>ICD-10 Code:</b>
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<b>Meningococcal Vaccination Status:</b>	<input type="checkbox"/> Primary vaccination series completed – date: _____
	<input type="checkbox"/> MenACWY booster completed – date: _____
	<input type="checkbox"/> MenB booster completed – date: _____

## Ecuzumab (Soliris®) Prescription

**Ecuzumab (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 1<sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> 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

<b>Prescriber Name:</b>	<b>Phone:</b>	<b>Fax:</b>
<b>Address:</b>	<b>NPI:</b>	
<b>City, State:</b>	<b>Zip:</b>	<b>Office Contact:</b>

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