

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: _____

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 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:

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