# ECULIZUMAB (SOLIRIS®) PRESCRIBER ORDER FORM

| Patient Name: | Date of Birth: | Gender: |
|---|---|---|
| **Address:** | | |

| Phone: | Height: | ☐ inches ☐ cm | Weight: | ☐ lbs ☐ kg |
|---|---|---|---|---|

## Clinical Information

| Primary Diagnosis Description: | ICD-10 Code: |
|---|---|

| Meningococcal Vaccination Status: | ☐ Primary vaccination series completed – date: _____<br>☐ MenACWY booster completed – date: _____<br>☐ 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.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

*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: 713-983-4647**



 