

ECULIZUMAB (SOLIRIS®) PRESCRIBER ORDER FORM

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



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 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

- Yes No

- Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ 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.
 - Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale

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:

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