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Soliris (Eculizumab) Infusion Order

Patient Name: DOB: □Male □Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication

□ Acetaminophen _____mg by □ PO
□ Cetirizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

Soliris is a weight-based medication:

Patient Height (cm):

Patient Weight (kg):

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ Soliris-REMS program enrollment
□ Documentation of meningococcal vaccines
□ Brain MRI (within one year)
□ Acetylcholine Receptor Antibody Test Results (if gMG)
□ List of tried & failed therapies (if gMG)
□ Aquaporin 4 Antibody Test Results (if NMO)
□ Other:

Soliris Medication Order:

aHUS, Myasthenia Gravis, and NMOSD (Adults)

□ Induction Dosing followed by maintenance
- Intravenous Dosing (Please choose one)
  - □ 900mg once weekly for 4 weeks, followed by 1200mg at week 5
- Maintenance Frequency (Please choose one)
  - □ 1200mg every two weeks

□ Maintenance dosing every 2 weeks
- Intravenous Dosing (Please choose one)
  - □1200mg

aHUS (Pediatrics)

□ Induction Dosing followed by maintenance
- Intravenous Dosing (Please choose one)
  - □ If >40kg, 900mg once weekly for 4 weeks, followed by 1200mg at week 5
  - □ If 30kg to ≤40kg, 600mg once weekly for 2 weeks, followed by 900mg at week 5
  - □ If 20kg to ≤30kg, 600mg once weekly for 2 weeks, followed by 600mg at week 3
  - □ If 10kg to ≤20kg, 600mg once, followed by 300mg at week 2
  - □ If 5kg to ≤10kg, 300mg once, followed by 300mg at week 2
- Maintenance Frequency (Please choose one)
  - □ 1200mg every two weeks □ 300mg every two weeks
  - □ 900mg every two weeks □ 300mg every three weeks
  - □ 600mg every two weeks

□ Maintenance dosing only
- Intravenous Dosing (Please choose one)
  - □ 1200mg every two weeks
  - □ 900mg every two weeks
  - □ 600mg every two weeks
  - □ 300mg every two weeks
  - □ 300mg every three weeks

PNH (Adults)

□ Induction Dosing followed by maintenance
- Intravenous Dosing (Please choose one)
  - □ 600mg once weekly for 4 weeks, followed by 1200mg at week 5
- Maintenance Frequency (Please choose one)
  - □ 900mg every two weeks

□ Maintenance dosing every 2 weeks
- Intravenous Dosing (Please choose one)
  - □ 900mg

Additional Instructions/Notes:

Patient IV Access □ PIV
□ Use patient's SL/DL PICC, flush per protocol □ Access/deaccess patient's Port, flush per protocol *Imaging results of proper placement required for PICC/Port

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:

□ *Skokie, IL*: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
□ *Libertyville, IL*: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
□ *Orland Park, IL:* 16612 107th Ct, Ste B. P: 847-324-6800. F: 224-251-7141
□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400