

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 to provide an anaphylaxis kit with the 1st dose?

- Yes – please complete Anaphylaxis Physician Order (FR-PC-036) No

Medication Orders

- Acetaminophen 650 mg PO 30 min before infusion. Patient may use own supply or patient may decline.
 Diphenhydramine 25 mg PO 30 min before infusion. Patient may use own supply or 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 administer doses intravenously. 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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