SandsRx Pharmacy

Phone: (844) 598-2557 Fax: (888) 388-1309

Soliris (Eculizumab)Prescriber Order Form

Please Fax completed form with patient's demographics,Clinical notes, and recent labs to (888) 388-1309

PATIENT

Patient Name: _____ Male Female **SS#:** _____ **DOB:** _____

Address: _____ **City, State, Zip:** _____

Primary Phone: _____ Home Cell Work **Alternate Phone:** _____ Home Cell Work

Email: _____

Allergies: _____

Clinical Information

Patient's Weight:_____Lbs (Required)

Diagnosis: ☐ Paroxysmal nocturnal hemoglobinuria (PNH) (ICD-10 Code: D59.5) ☐ Neuromyelitis Optica Spectrum disorders (NMOSD) (ICD-10 Code: G36.0)

☐ Atypical hemolytic uremic syndrome (aHUS) (ICD-10 Code: D59.3) ☐ Other: _____ (ICD-10 Code: _____)

☐ Myasthenia Gravis w/out acute exacerbation (gMG) (ICD-10 Code: G70.00)

Myasthenia Classification: ☐ II ☐ III ☐ IV

Soliris Prescription Order (Prescriber MUST be enrolled in Soliris REMS)

Soliris Adult Dosing:

PNH Diagnosis

☐ Initial Start: 600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every 2 weeks thereafter x 1 year

☐ Maintenance Dose: 900mg IV every 2 weeks x 1 year

aHUS, gMG, and NMOSD Diagnosis

☐ Initial dose: 900mg IV weekly for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter x 1 year

☐ Maintenance Dose: 1200mg IV every 2 weeks x 1 year

Ancillary Orders

Anaphylaxis Kit If this is a 1st infusion dose, would you like SandsRx Pharmacy to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

Dosage:

- Give Diphenhydramine capsule (s) 25 mg to 50 mg PO as needed **#4 capsules**
- 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. **#2 vials**
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement. **#1 vial**
- 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.

Pre- Medication Orders

☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.

☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.

☐ Loratadine 10 mg PO 30 min before infusion. Patient may decline.

☐ Methylprednisolone Succinate _____ mg IV push 20 minutes prior to infusion.

☐ 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 Nursing Visits: As needed for IV access, administration and appropriate clinical monitoring. Administration procedures to be followed per protocol. Pump and supplies as needed for administration and appropriate disposal of infusion materials. 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:**	