EXPECARE FAMILY CARE | URGENT CARE OF TEXAS

Soliris Order Form
(eculizumab)

FAX TO: 817-472-7213

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code
- ☐ D58.8 Other Specified Hereditary Hemolytic Anemias
- ☐ D59.3 Hemolytic Uremic Syndrome
- ☐ D59.4 Other Non-Autoimmune Hemolytic Anemias (Including Microangiopathic Hemolyticanemia)
- ☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria
- ☐ D59.8 Other Acquired Heamolytic Anemias

ICD 10 Code
- ☐ G36.0 Neuromyelitis Optica
- ☐ G70.00 Generalized Myasthenia Gravis, w/o Acute Exacerbation
- ☐ G70.01 Generalized Myasthenia Gravis, w/Acute Exacerbation

Other: _____

Prescribing Information
Meningococcal document required for all diagnoses. See Pre-Medications and Required Labs by diagnosis below.

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Include labs to support diagnosis.**

PRESCRIPTION

SOLIRIS	DILUENT VOLUME	FINAL VOLUME
300 mg	30 mL	60 mL
600 mg	60 mL	120 mL
900 mg	90 mL	180 mL
1200 mg	120 mL	240 mL

SOLIRIS (eculizumab)
Administer over at least 35 minutes in adults, not to exceed 2 hours.

PAROXUSMAL NOCTURNAL HEMOGLOBINURIA (PNH)

Loading Dose
☐ **IV:** Infuse 600 mg dose weekly for first 4 weeks followed by 900 mg dose at week 5

Maintenance Dose
☐ **IV:** Infuse 900 mg dose every 2 weeks for one year

Pre-Medications
- ☐ Acetaminophen: 650 mg PO
- ☐ Cetirizine: 10 mg PO
- ☐ Diphenhydramine: 25 mg PO
- ☐ Diphenhydramine: 25 mg IVP

Other: _____

Required Labs
- Baseline Serum Lactage Dehydrogenase (LHD) Hemoglobin Level
- Documented Meningococcal Vaccine

ATYPICAL HEMOLYTIC UREMIC SYNDROME (aHUS)

Loading Dose
☐ **IV:** Infuse 900 mg dose weekly for first 4 weeks followed by 1200 mg dose at week 5

Maintenance Dose
☐ **IV:** Infuse 1200 mg dose every 2 weeks for one year

Pre-Medications
- ☐ Acetaminophen: 650 mg PO
- ☐ Cetirizine: 10 mg PO
- ☐ Diphenhydramine: 25 mg PO
- ☐ Diphenhydramine: 25 mg IVP

Other: _____

Required Labs
- Baseline Serum Lactate Dehydrogenase (LHD) Hemoglobin Level
- Serum Creatinine/eGFR
- Platelet Count
- Plasma Exchange
- Documented Meninococcal Vaccine

GENERALIZED MYASTHENIA GRAVIS (gMG) and NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)

Loading Dose
☐ **IV:** Infuse 900 mg dose weekly for first 4 weeks followed by 1200 mg dose at week 5

Maintenance Dose
☐ **IV:** Infuse 1200 mg dose every 2 weeks for one year

Pre-Medications
- ☐ Acetaminophen: 650 mg PO
- ☐ Cetirizine: 10 mg PO
- ☐ Diphenhydramine: 25 mg PO
- ☐ Diphenhydramine: 25 mg IVP

Other: _____

Required Labs
- Positive Serologic Test for Anti-AChR Antibodies
- Documented Meningococcal Vaccine

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose:
_____

Post Treatment Observations: The patient is observed for 60 minutes following the first administration.

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____