Eculizumab (Soliris)

Provider Order Form rev. 12/01/2021

AleraCare
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

ICD-10 CODE

☐ D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)

☐ D59.3 Atypical hemolytic uremic syndrome (aHUS)

☐ G70.01 Generalized myasthenia gravis (gMG)

☐ G36.0 Neuromyelitis optica spectrum disorder (NMOSD)

☐ Other: _____

SPECIAL INSTRUCTIONS

MEDICATION ORDER

☑ **Eculizumab** (Soliris) in 0.9% sodium chloride, intravenous infusion

- Dose: Induction: (Choose one. If patient has already completed induction dose, proceed to maintenance dose.)
  - ☐ 600mg weekly for the first four weeks followed by 900mg for the fifth dose one week later, then 900mg two weeks later
  - ☐ 900mg weekly for the first four weeks followed by 1200mg for the fifth dose one week later, then 1200mg two weeks later
- Dose: Maintenance: (Choose one)
  ☐ 900mg every two weeks ☐ 1200mg every two weeks
- Dilute with 0.9% NS to a final concentration of 5mg/ml. (300mg doses final volume 60ml, 600mg doses final volume 120ml, 900mg doses final volume 180ml, 1200mg doses final volume 240ml.)
- Infuse over 35 minutes in adults and 1-4 hours in pediatric patients
- ☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 60-minute observation period

☐ Patient is NOT required to stay for observation time

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

Provider Name (Print) **Provider Signature** **Date**

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ ANA (SLE) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months