

Ecuzumab (Soliris) p1

Provider Order Form rev. 3/1/2023



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PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____

ICD-10 code (required): _____ ICD-10 description: _____

NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

- Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation
- Meningococcal vaccination (both conjugate and serogroup B) are required prior to initiating Soliris infusions.
- Check here if patient has already received vaccines. Fax or attach documentation of administered vaccines.
- Check here for 360 Infusion Center to administer vaccines as outlined below.

MENINGITIS VACCINE - Patients are required to receive first dose of both Conjugate and serogroup b vaccines prior to initiating Soliris.

Unless otherwise noted, vaccines will be given 2 weeks prior to starting Soliris infusion. 360 will schedule the patient for vaccine visit followed by Soliris two weeks later. If **urgent** Soliris therapy is indicated in an unvaccinated patient, 360 Infusion Center will administer meningococcal vaccine(s) as soon as possible including same day as Soliris infusion.

Additionally, provider **must prescribe** patients with 2 weeks of antibacterial drug prophylaxis.

Check here if this is an **urgent** start.

360 WILL ADMINISTER BOTH VACCINES AS OUTLINED BELOW.

Meningococcal conjugate (MenACWY) vaccine

(Patient will be given either Menactra or Menveo vaccine based on availability and will receive **two doses separate by at least eight weeks**. Menactra and Menveo are not interchangeable and patient will receive same product for all doses in a series.)

Serogroup B Meningococcal (MenB) vaccine

(Patient will be given Bexsero or Trumenba vaccine based on availability and will receive either the two-dose series Bexsero at least one month apart or three-dose series Trumenba at 0, 1-2, and 6 months. Bexsero and Trumenba are not interchangeable and patient will receive same product for all doses in a series.)

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- Other: _____

PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg / 50mg PO / IV
- methylprednisolone (Solu-Medrol) 40mg / 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: _____
- Dose: _____ Route: _____
- Frequency: _____

THERAPY ADMINISTRATION

- Ecuzumab (Soliris)** in 0.9% sodium chloride, IV 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
- Refills: Zero / for 12 months / _____ (if not indicated order will expire one year from date signed)

Monitor the patient for at least one hour following completion of the infusion for signs or symptoms of an infusion reaction.

Eculizumab (Soliris) P2

Provider Order Form rev. 10/12/2022

Date: Patient Name: DOB:

SPECIAL INSTRUCTIONS

Provider Name (Print) Provider Signature Date