ArrIVe
INFUSION THERAPY

An Outpatient Department of Trinity Health Oakland
9400 Village Place Blvd, Brighton, MI 48116-2084
Phone: 810-844-7373
Fax: 810-844-7366

# Eculizumab (Soliris®)

*Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVe Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.*

**Order Date:** ____/____/____

**Referral Status:** ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

| | |
|---|---|
| **Patient Name**: _____<br>**Patient Address:** _____<br>**Patient Phone Number:** _____<br>**Date of Birth**: ____/____/____<br>**Weight:** _____kg **Height:** _____cm<br>**Allergies:** _____ | **Primary Insurance:** _____<br>**Member ID:** _____<br>**Secondary Insurance:** _____<br>**Member ID:** _____ |
| **Diagnosis**<br><br>☐ Hemolytic uremic syndrome (AHUS) (D59.3)<br>☐ Paroxysmal nocturnal hemoglobinuria (PNH) (D59.5)<br>☐ Neuromyelitis optica (NMOSD) (G36.0)<br>☐ Myasthenia gravis without acute exacerbation (G70.00)<br>☐ Myasthenia gravis with acute exacerbation (G70.01)<br>☐ Other Diagnosis Code (ICD-10): _____<br>☐ Other Indication: _____<br>Target start date: _____ | **Labs**<br><br>☐ No labs ordered at this time<br>☐ Other: _____ |

**Note:** Meningococcal documentation required for all diagnoses:

☐ Primary vaccination series completed – date: _____
☐ MenACWY booster completed – date: _____
☐ MenB booster completed – date: _____

## Eculizumab (Soliris®)

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. Observe patient for 60 minutes post completion of infusion.**

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| | | |
|---|---|---|
| **Pre-Medications and Pre-Protocol** (ordered at physician discretion) | ☐ Acetaminophen 650 mg PO once<br>☐ Loratadine 10 mg PO once<br>☐ Diphenhydramine once<br>☐25 mg ☐50 mg<br>☐ PO ☐IV<br>☐ Famotidine 20 mg IV once<br>☐ Hydrocortisone 100 mg IV once<br>☐ Methylprednisolone 125 mg IVP once<br>☐ Other: _____ | **Hydration**<br>☐ LR<br>☐ Sodium Chloride 0.9%<br>☐ Other _____<br>_____ mL at _____mL/hr<br>☐ Before ☐ During ☐ Following |
| **Flushing Protocol** (pre and post medication) | ☐ Sodium Chloride 0.9% ☐ 5 mL ☐ 10 mL as needed for line care | ☐ Heparin _____Units/mL _____mL as needed for line care |
| **Hypersensitivity Panel**<br>Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary | • **Sodium chloride** 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg)<br>• **Acetaminophen** 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping<br>• **Albuterol** 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses<br>• **Albuterol HFA** inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea<br>• **Epinephrine** injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses<br>• **Famotidine** injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure<br>• **Diphenhydramine** injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom<br>• **Diphenhydramine** injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure<br>• **Hydrocortisone** sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure | |

Provider Name: _____ Provider Signature: _____

Attending Physician Name: _____ Provider NPI: _____

Office Phone Number: _____ Office Fax Number: _____

*(If ordering provider is an advanced practice practitioner)*
*Note: This order is valid for 12 months from date of physician signature.*

**Submit**