An Outpatient Department of St. Mary's Hospital
2421 Malcom Bridge Rd Ste 820 Bogart, GA 30622-2325
Phone: 706-389-7802
Fax: 706-389-2501

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

Note: Meningococcal documentation required for all diagnoses:

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

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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.

ArrIVe INFUSION THERAPY

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Pre-Medications and Pre-Protocol (ordered at physician discretion)	☐ Acetaminophen 650 mg PO once ☐ Loratadine 10 mg PO once ☐ Diphenhydramine once ☐25 mg ☐50 mg ☐ PO ☐IV ☐ Famotidine 20 mg IV once ☐ Hydrocortisone 100 mg IV once ☐ Methylprednisolone 125 mg IVP once ☐ Other: _____	**Hydration** ☐ LR ☐ Sodium Chloride 0.9% ☐ Other _____ _____ mL at _____mL/hr ☐ 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 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) • **Acetaminophen** 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • **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 • **Albuterol HFA** inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • **Epinephrine** injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • **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 • **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 • **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 • **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

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