ECULIZUMAB (SOLIRIS®) PRESCRIBER ORDER FORM

Ascension at Home | TOGETHER WITH COMPASSUS®
Appleton and Oak Creek, WI
t 800-648-8055 f 414-563-0600

Fax completed form, insurance information, and clinical documentation to:

Patient Name:		Date of Birth:		
Address:				
Phone:	Height:	☐ inches ☐ cm	Weight:	☐ lbs ☐ kg

CLINICAL INFORMATION

Primary Diagnosis Description: **ICD-10 Code:**

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

ECULIZUMAB (SOLIRIS®) PRESCRIPTION

Eculizumab (Soliris®) refill as directed x 1 year

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.

ANCILLARY ORDERS

Anaphylaxis Kit

If this is a 1st dose, would you like Ascension at Home to provide an anaphylaxis kit with the 1st dose?
☐ Yes ☐ No

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25mg PO or IV/IM. May repeat additionally 25mg PO or IV PRN.
- Normal saline 500 mL (> 30 kg) or 250 mL (< 30 kg) IV at KVO rate PRN anaphylaxis. Patient < 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Medication Orders

☐ Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.
☐ Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.
☐ Other: _____

IV Flush Orders

☐ Peripheral: NS 2 to 3 mL pre-/post-use.
☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.
☐ Other: _____

Skilled nurse to initiate IV access for administration of doses in the home or alternate care setting. Access to be discontinued upon completion of infusion. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

PRESCRIBER INFORMATION

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	