# ECULIZUMAB (SOLIRIS®)
# PRESCRIBER ORDER FORM

COMPASSUS®

Fax completed form, insurance information, and clinical documentation to: **t** 888-386-0886 **f** 586-263-3306

| | | | | |
|---|---|---|---|---|
| Patient Name: | | | Date of Birth: | |
| Address: | | | Last 4 of SS #: | |
| Phone: | Height: | ☐ inches ☐ cm | Weight: | ☐ lbs ☐ kg |

## CLINICAL INFORMATION

| | |
|---|---|
| **Primary Diagnosis Description:** | **ICD-10 Code:** |
| **Medications previously tried and failed (list medication and duration of use):** | **Has patient received Botox®?**<br>☐ Yes, # of injections: _____<br>☐ No |

## PRESCRIPTION

**For existing Vyepti patients:** Date of last infusion: _____

**Vyepti® (Eptinezumab-jjmr) refill as directed x 1 year**

☐ Infuse 100 mg IV over 30 minutes once every 3 months

☐ Infuse 300 mg IV over 30 minutes once every 3 months

Using a 50ml NS IV bag, flush IV tubing with NS 10 to 20 mL after each infusion

Infuse via a 0.2 micron in-line filter

Dispense quantity sufficient of Vyepti® 100 mg single dose vials for each dose

## ANCILLARY ORDERS

**Anaphylaxis Kit**

If this is a 1st dose, would you like Compassus 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.

**Pre-Medication Orders**

☐ 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.

☐ Other: _____

**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:** | |