



 Soliris (eculizumab) IV Infusion Order Form

 405-442-7577  405-442-7223

 orders@premierinfusioncenter.com

 Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / ____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

◆ **Diagnosis (ICD-10 Selection)**

- ☐ D59.5 – Paroxysmal nocturnal hemoglobinuria (PNH)
- ☐ D59.3 – Atypical hemolytic uremic syndrome (aHUS)
- ☐ G36.0 – Neuromyelitis optica spectrum disorder (NMOSD)
- ☐ G70.00 – Myasthenia gravis without acute exacerbation
- ☐ G70.01 – Myasthenia gravis with acute exacerbation
- ☐ Other: _____ **ICD-10 Code:** _____

◆ **Infusion Order**

- **Induction Phase:**
 - ☐ 600 mg IV weekly × 4 weeks, then 900 mg IV at Week 5
 - ☐ 900 mg IV weekly × 4 weeks, then 1200 mg IV at Week 5
- **Maintenance Phase:**
 - ☐ 900 mg IV every 2 weeks
 - ☐ 1200 mg IV every 2 weeks
- ☐ Dilute in 0.9% sodium chloride to final concentration of 5 mg/mL
- ☐ Infuse over ≥35 minutes (max 2 hours)
- ☐ Observation: ☐ 60 minutes post-infusion
- ☐ Refills: ☐ None ☐ 12 months ☐ Other: _____

◆ **Meningococcal Vaccination**

- ☐ Documentation of completed MenACWY and MenB series attached
- ☐ Patient to receive MenACWY and MenB vaccines ≥ 2 weeks prior to first dose
- ☐ Provider acknowledges patient may begin Soliris before vaccine series completion and assumes responsibility for antimicrobial prophylaxis

◆ **Line Use & Access**

- ☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard infusion protocol

◆ **Adverse Reaction & Anaphylaxis Orders**

- ☐ Premier Infusion Center Protocol (premierinfusioncenter.com)
- ☐ Other – please fax preferred reaction orders to 405-442-7223

◆ **Premedication (Recommended)**

- ☐ Acetaminophen: ☐ 650 mg ☐ 1000 mg ☐ PO
- ☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
- ☐ Loratadine: ☐ 10 mg ☐ PO
- ☐ Methylprednisolone: ☐ 125 mg ☐ IV
- ☐ Hydrocortisone: ☐ 100 mg ☐ IV
- ☐ Other: _____ **Dose:** _____ **Route:** _____

◆ **Laboratory Monitoring**

- ☐ CBC ☐ CMP ☐ LDH ☐ Hemoglobin
- ☐ Creatinine/eGFR ☐ Platelet count ☐ Anti-AChR antibody
- ☐ Other: _____
- Frequency:** ☐ Prior to first dose ☐ Each infusion ☐ Monthly ☐ Other: _____
- ☐ Physician office will order labs only

◆ **Clinical Documentation Checklist**

- ☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
- ☐ Documentation of prior therapies or intolerance
- ☐ Meningococcal vaccine records

◆ **Ordering Provider & Demographics**

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / ____ / ____