

ECULIZUMAB (SOLIRIS®) PRESCRIBER ORDER FORM

FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128

☐ NEW PATIENT OR

☐ CHANGE ORDER: ☐ Drug Change ☐ Dose Change ☐ Interval Change

Patient Name: _____ Date of Birth: _____

Phone: _____ Gender: _____

Address: _____

Allergies: _____

Height: ☐ in ☐ 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: _____

PRESCRIPTION

Ecuzumab (Soliris®) refill as directed x 1 year

Induction Dose: ☐ Infuse 600mg IV over at least 35 minutes weekly x 4 weeks

☐ Infuse 900mg IV over at least 35 minutes weekly x 4 weeks

☐ Other: _____

Maintenance Dose: ☐ Infuse 900mg IV over at least 35 minutes on week 5, then every 2 weeks thereafter

☐ Infuse 1200mg IV over at least 35 minutes on week 5, then every 2 weeks thereafter

☐ Infuse _____mg IV over at least 35 minutes 2 weeks

☐ Other: _____

Max infusion time not to exceed 2 hours.

ANCILLARY ORDERS

Pre-Medication Orders

☐ Acetaminophen 650mg PO 30 minutes before infusion. *Patient may decline.*

☐ Diphenhydramine 25mg PO/IV 30 minutes before infusion. *Patient may decline.*

☐ Cetirizine 10mg IV 30 minutes before infusion.

☐ Other: _____

PRN Hypersensitivity Meds:

• Epinephrine 0.3mg

• Solu-Cortef 100mg

• Solu-Medrol 125mg

• Diphenhydramine 25-50mg

• NS 500 ML (>30kg)

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: _____

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