Virginia Oncology Associates
MSIC
Multispecialty Infusion Clinic

(757) 271-0969 call
(757) 466-1128 fax

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

Eculizumab (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:**	