ORDERING OFFICE, ALSO FAX:

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

Eculizumab (Soliris)

Provider Order Form

IVX HEALTH formerly Infusion Express

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:

NURSING

- ☑ Provide nursing care per IVX Standard Nursing Procedures, including reaction management and post infusion observation.
- ☑ Meningococcal vaccination status and date (Please provide date given/results) _____

MENINGITIS VACCINE

If your patient is needing the Meningococcal vaccine, please check the appropriate boxes below.

- ☐ Meningococcal conjugate (MenACWY) vaccine
  (Patient will be given either Menactra or Menveo vaccine based on availability and will receive two doses separate by at least eight weeks. Menactra and Menveo are not interchangeable and patient will receive same product for all doses in a series.)
- ☐ Serogroup B Meningococcal (MenB) vaccine
  (Patient will be given Bexsero or Trumenba vaccine based on availability and will receive either the two-dose series Bexsero at least one month apart or three-dose series Trumenba at 0, 1-2, and 6 months. Bexsero and Trumenba are not interchangeable and patient will receive same product for all doses in a series.)

Choose one of the following to indicate dosing schedule.

- ☐ Vaccines may be given same day as starting Soliris infusion ☐ Vaccines must be given 2 weeks prior to starting Soliris infusion
  (Immunize patients without a history of meningococcal vaccination at least 2 weeks prior to receiving the first dose of Soliris. If urgent Soliris therapy is indicated in an unvaccinated patient, administer meningococcal vaccine(s) as soon as possible and provide patients with 2 weeks of antibacterial drug prophylaxis.)

LABORATORY ORDERS

- ☐ CBC ☐ every other dose ☐ every _____
- ☐ CMP ☐ every other dose ☐ every _____
- ☐ Other:

PRE-MEDICATION ORDERS (ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
- ☐ cetirizine (Zyrtec) 10mg PO
- ☐ loratadine (Claritin) 10mg PO
- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
- ☐ Other: _____ Dose: _____ Route: _____ Frequency: _____

INFUSION THERAPY

- ☑ eculizumab (Soliris) in 0.9% sodium chloride, intravenous infusion
  - Dose: Induction: (Choose one. If patient has already completed induction dose, proceed to maintenance dose.)
    ☐ 600mg weekly for the first four weeks followed by 900mg for the fifth dose one week later, then 900mg two weeks later
    ☐ 900mg weekly for the first four weeks followed by 1200mg for the fifth dose one week later, then 1200mg two weeks later
  - Dose: Maintenance: (Choose one)
    ☐ 900mg every two weeks ☐ 1200mg every two weeks
  - Dilute with 0.9% NS to a final concentration of 5mg/ml. (300mg doses final volume 60ml, 600mg doses final volume 120ml, 900mg doses final volume 180ml, 1200mg doses final volume 240ml.)
  - Infuse over 35 minutes in adults and 1-4 hours in pediatric patients
- ☑ Flush with 0.9% sodium chloride at the completion of infusion
- ☐ Patient is required to stay for one-hour observation post infusion
- ☐ Patient is NOT required to stay for observation time
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____(if not indicated order will expire one year from date signed)

GENERAL PLAN COMMUNICATION

Special instructions/notes:

Ordering Provider: Initial here _____ and proceed to the next page.

ADULT REACTION MANAGEMENT

- ☑ Observe for **hypersensitivity reaction:** Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation
- ☑ If reaction occurs:
  - Stop infusion
  - Maintain/establish vascular access
  - Notify referring provider
  - Consider giving the following PRN
    1. Acetaminophen (Tylenol) 650mg PO **OR**_____mg for pain or fever > 38 C/100.4 F
    2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
    3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
    4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
    5. Methylprednisolone (Solumedrol) 125mg **OR** _____mg slow IV push.
    6. Other _____
  - When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's guidelines

- ☑ **Severe allergic/anaphylactic reaction:**
  - If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
    1. Call 911
    2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
    3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
    4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
    5. Have Automated External Defibrillator available
    6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
    7. Discontinue treatment

Immunize patients without a history of meningococcal vaccination at least 2 weeks prior to receiving the first dose of Soliris. If urgent Soliris therapy is indicated in an unvaccinated patient, administer meningococcal vaccine(s) as soon as possible and provide patients with 2 weeks of antibacterial drug prophylaxis.

Monitor the patient for at least one hour following completion of the infusion for signs or symptoms of an infusion reaction.

Patient Name _____ **Patient Date of Birth** _____

Provider Name (Print) _____

Provider Signature _____ **Date** _____

Designate the desired location and fax the order form to:

CALIFORNIA fax: (844) 889-0275 | ☐ San Mateo ☐ Fremont ☐ San Ramon ☐ TBD

ILLINOIS fax: (312) 253-7244 | ☐ Glenview ☐ Schaumburg ☐ TBD

KANSAS / MISSOURI fax: (844) 900-1292 | ☐ Overland Park, KS ☐ Lee's Summit, MO ☐ Briarcliff, MO ☐ TBD

OHIO fax: (844) 627-2675 | ☐ Dublin ☐ Pickerington ☐ TBD

PENNSYLVANIA fax: (844) 820-9641 | ☐ Malvern ☐ Bensalem ☐ Montgomeryville ☐ East Shore ☐ West Shore ☐ TBD

TENNESSEE fax: (844) 627-2518 | ☐ Brentwood ☐ Hendersonville ☐ TBD

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