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adaptIV infusion

Soliris (Eculizumab)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation
☐ Meningococcal vaccination (both conjugate and serogroup B) are required prior to initiating Soliris infusions.
☐ Check here if patient has already received vaccines. Fax or attach documentation of administered vaccines.
☐ Check here for AdaptIV Infusion to administer vaccines as outlined below.

MENINGITIS VACCINE - Patients are required to receive first dose of both Conjugate and serogroup b vaccines prior to initiating Soliris.

Unless otherwise noted, vaccines will be given 2 weeks prior to starting Soliris infusion. AdaptIV Infusion will schedule the patient for vaccine visit followed by Soliris two weeks later. If urgent Soliris therapy is indicated in an unvaccinated patient, AdaptIV Infusion will administer meningococcal vaccine(s) as soon as possible including same day as Soliris infusion. Additionally, provider must prescribe patients with 2 weeks of antibacterial drug prophylaxis.

☐ Check here if this is an **urgent** start.

ADAPTIV INFUSION WILL ADMINISTER BOTH VACCINES AS OUTLINED BELOW.

Meningococcal conjugate (MenACWY) vaccine

(Patient will be given either Menactra or Menveo vaccine based on availability and will receive **two doses separated 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.)

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

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Eculizumab** (Soliris) in 0.9% sodium chloride, IV 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 infusion completion
☐ Patient is required to stay for 60 min. observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

Please continue to next page.

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK

adaptIV infusion

_____ / _____ / _____
Today's Date

_____
Patient Name (Print)

_____ / _____ / _____
DOB

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____
Provider Name (Print)

_____
Provider Signature

_____
Date

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK