Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Soliris® (eculizumab) Standard Plan of Treatment for Myasthenia Gravis

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ G70.00 - Myasthenia Gravis without acute exacerbation ☐ G70.01 - Myasthenia Gravis with acute exacerbation

☐ _____ - Other:_____

REQUESTED DOCUMENTATION:

1	Insurance information
2	History & Physical/Tried and failed therapies
3	Full medication list
4	**REQUIRED:** Documentation of meningococcal vaccine (MenACWY AND MenB) at least 2 weeks prior to start of therapy

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive eculizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, presents with any symptoms of meningococcal infections, and/or surgery.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*FDA labeling does not suggest any premedication prior to infusion

IV	Diphenhydramine	◯	25mg	◯	50mg				
	Methylprednisolone	◯	40mg	◯	125mg	◯	Other:		
	Famotidine	◯	20mg	◯	40 mg				
	Other:	◯							

PO	Acetaminophen	◯	325mg	◯	500mg	◯	650mg	◯	1000mg
	Famotidine	◯	20mg	◯	40mg				
	Diphenhydramine	◯	25mg	◯	50mg				
	Fexofenadine	◯	60mg	◯	180mg				
	Cetirizine	◯	10mg						
	Loratadine	◯	10mg						
	Other:	◯							

MEDICATION:

☑ Soliris® (eculizumab) IV given over 35 minutes diluted in NS according to FDA labeling suggestions

If the infusion is slowed, the total infusion time should not exceed 2 hours.

Follow each infusion with a 1 hour post infusion monitoring

SPECIAL/OTHER LAB ORDERS:

◯ _____

_____

FREQUENCY/DOSE:

◯ Induction: 900mg IV given weekly for 4 weeks

◯ Maintenance (to begin on week 5 if receiving induction): 1200mg IV given once every 2 weeks

◯ Other:_____

Prescriber must be enrolled in the Soliris (REMS) program, at 1 888 765 4747 or at www.solirisrems.com.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	