

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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:
<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> 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	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		<b>IF ORDER CHANGE:</b>
5	Documented meningococcal vaccine administration (Both MenACWY AND MenB)		

### 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

<b>IV</b>	Diphenhydramine	25mg	50mg		<b>PO</b>	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					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:

<input type="checkbox"/>	Induction: 900mg IV given weekly for 4 weeks
<input type="checkbox"/>	Maintenance (to begin on week 5 if receiving induction): 1200mg IV given once every 2 weeks
<input type="checkbox"/>	Other: _____

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