| 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: | | PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE? | |
|---|---|---|---|
| 1 | Insurance information | IF NO: | IF YES: |
| 2 | History & Physical/Tried and failed therapies | PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY: | LAST INFUSION DATE: |
| 3 | Full medication list | | NEXT INFUSION DATE: |
| 4 | **REQUIRED:** Documentation of meningococcal vaccine (MenACWY AND MenB) at least 2 weeks prior to start of therapy | | **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 | |

Palmetto
INFUSION

# Checklist for referrals to Palmetto Infusion:

## Fax referral to 1.866.872.8920

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

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