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 Neuromyelitis Optica Spectrum Disorder

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)

	G36.0 - Neuromyelitis Optica Spectrum Disorder		
	________- Other:____		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Documented meningococcal vaccine administration (Both MenACWY AND MenB)

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	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 per 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:

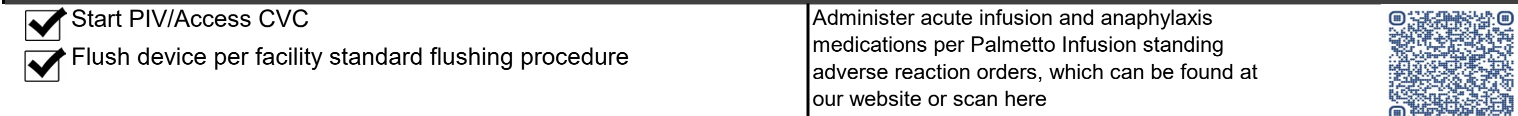
☐ Induction: 900mg IV given weekly for 4 weeks

☐ Maintenance (to begin at 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	