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

Soliris® (eculizumab) Standard Plan of Treatment for Pediatric aHUS

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)

	D59.3 - Atypical Hemolytic Uremic Syndrome (aHUS)		D59.4 - Other non autoimmune hemolytic anemias (including microangiopathic hemolytic anemia)
	D58.8 - Other specified hereditary hemolytic anemias		
	D59.8 - Other acquired hemolytic anemias		
	________- 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		160mg/5ml	mls
	Famotidine		20mg		40mg			
	Diphenhydramine		25mg		50mg		12.5mg/5ml:	mls
	Loratadine		10mg					
	Other:							

MEDICATION:

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

Follow each infusion with a 1 hour post infusion monitoring

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

FREQUENCY/DOSE:

Patient body weight	Induction	Maintenance
≥ 40kg	900 mg weekly x 4 doses	1200 mg at week 5; then 1200 mg every 2 weeks thereafter
30kg to less than 40kg	600 mg weekly x 2 doses	900 mg at week 3; then 900 mg every 2 weeks thereafter
20kg to less than 30kg	600 mg weekly x 2 doses	600 mg at week 3; then 600 mg every 2 weeks thereafter
10kg to less than 20kg	600 mg weekly x 1 dose	300 mg at week 2; then 300 mg every 2 weeks thereafter
5kg to less than 10kg	300 mg weekly x 1 dose	300 mg at week 2; then 300 mg every 3 weeks thereafter

Prescriber must be enrolled in the Soliris (REMS) program, at 18887654747 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/AccuRX 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	

Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- ☐ **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. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

02/08/2023

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