

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 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: <input type="checkbox"/> See list <input type="checkbox"/> 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	D59.32 - Hereditary hemolytic - uremic syndrome
D59.8 - Other acquired hemolytic anemias	
D59.39 - Other hemolytic- uremic syndrome	
- Other:	

REQUESTED DOCUMENTATION:

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	PO	Acetaminophen	325mg	500mg	160mg/5ml	mls	
	Methylprednisolone	40mg	125mg		Other:	Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg	12.5mg/5ml:	mls
	Other:					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

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 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	