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 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	☐	D59.32 - Hereditary hemolytic - uremic syndrome
☐	D59.39 - Other hemolytic- uremic syndrome	☐	_____- Other:_____

REQUESTED DOCUMENTATION:

1	Insurance information
2	History & Physical/Tried and failed therapies
3	Full medication list
4	**REQUIRED:** Documentation of meningococcal vaccine (MenACWY AND MenB) at least 2 weeks prior to start of therapy

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

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 1-4 hours diluted in NS according to FDA labeling suggestions.

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

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

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	