

# Soliris® (eculizumab) Standard Plan of Treatment for Myasthenia Gravis

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

## PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG Gender: Allergies: See list NKDA

## DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

G70.00 - Myasthenia Gravis without acute exacerbation	G70.01 - Myasthenia Gravis with acute exacerbation
- 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	<b>REQUIRED:</b> Documentation of meningococcal vaccine (MenACWY AND MenB) at least 2 weeks prior to start of therapy		<b>IF ORDER CHANGE:</b>
			<b>Continue current order until insurance approved</b>

## 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	Other:	PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg			Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					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:

<input type="checkbox"/>	Induction: 900mg in 180ml NS IV given weekly for 4 weeks
<input type="checkbox"/>	Maintenance (to begin on week 5 if receiving induction): 1200mg in 240ml NS IV given once every 2 weeks
<input type="checkbox"/>	Other: _____

**Prescriber must be enrolled in the Soliris (REMS) program, at 1 888 765 4747 or at [www.solirisrems.com](http://www.solirisrems.com).**

Refills x 12 months unless noted otherwise here:

## NURSING 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.

## 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