

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 Neuromyelitis Optica Spectrum Disorder

PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	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)

G36.0 - Neuromyelitis Optica Spectrum Disorder	- Other:
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REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	History & Physical/Tried and failed therapies	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	REQUIRED: Documentation of meningococcal vaccine (MenACWY AND MenB) at least 2 weeks prior to start of therapy	FROM PREVIOUS 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	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
						Cetirizine	10mg			
				Loratadine	10mg					
				Other:						

MEDICATION:

Soliris® (eculizumab) IV given over 35 minutes in 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:

<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

FREQUENCY/DOSE:

<input type="checkbox"/>	Induction: 900mg in 180ml NS IV given weekly for 4 weeks
<input type="checkbox"/>	Maintenance (to begin at 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.

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

<input checked="" type="checkbox"/>	Start PIV/Access CVC
<input checked="" type="checkbox"/>	Flush device per facility standard flushing procedure
<input checked="" type="checkbox"/>	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