

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

Rev 4.29.25

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

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

### REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

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		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		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 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:

\_\_\_\_\_  
 \_\_\_\_\_

### 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](http://www.solirisrems.com).

Refills x 12 months unless noted otherwise here:

### LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS 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	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



## Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

[www.palmettoinfusion.com](http://www.palmettoinfusion.com)