

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

Soliris® (eculizumab) Standard Plan of Treatment for Pediatric aHUS

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 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	- Other: _____
D59.39 - Other hemolytic- uremic syndrome	

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: _____ IF YES: _____
 PLEASE STATE LAST INFUSION DATE: _____
 REQUIRED WASHOUT FROM PREVIOUS THERAPY: _____ 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	Other:	PO	Acetaminophen	325mg	500mg	160mg/5ml	mls
	Methylprednisolone	40mg	125mg			Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg	12.5mg/5ml:	mls
	Other:					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.

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