Referral Status:		MRN:	
☐	New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:			

Rev. 4.29.25

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		
☐	D59.8 - Other acquired hemolytic anemias	☐	D59.32 - Hereditary hemolytic - uremic syndrome
☐	D59.39 - Other hemolytic- uremic syndrome	☐	_____- 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	**REQUIRED:** Documentation of meningococcal vaccine (MenACWY AND MenB) at least 2 weeks prior to start of 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				
	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.

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	

Palmetto INFUSION

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