Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

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

Soliris® (eculizumab) Standard Plan of Treatment for aHUS

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		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:

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**

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

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	☐ 650mg	☐ 1000mg				
	Famotidine	☐ 20mg	☐ 40mg						
	Diphenhydramine	☐ 25mg	☐ 50mg						
	Fexofenadine	☐ 60mg	☐ 180mg						
	Cetirizine	☐ 10mg							
	Loratadine	☐ 10mg							
	Other:	☐							

MEDICATION:

☑ Soliris® (eculizumab) IV given over 35 minutes diluted in NS according to FDA labeling instructions

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:

☐ Induction: 900mg IV weekly for 4 weeks

☐ Maintenance (to begin at week 5 if receiving induction): 1200mg IV every 2 weeks

☐ 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:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

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	