ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Eculizumab is part of **FDA REMS** Program
    a. Providers MUST be enrolled in the SOLIRIS REMS.
    b. Provide patient with both the Patient Safety Brochure and Patient Safety Card. Patient should carry the card with them at all times.
    c. Please see reference links below for enrollment forms and additional help
        i. https://solirisrems.com/
        ii. https://solirisrems.com/Soliris-Prescriber-Enrollment-Form
        iii. https://solirisrems.com/Soliris-Prescriber-Safety-Brochure
        iv. https://solirisrems.com/Soliris-Patient-Safety-Brochure
        v. https://solirisrems.com/Soliris-Patient-Safety-Card
3. Patients must receive the following meningococcal vaccine at least 2 weeks prior to treatment initiation:
    a. Meningococcal serogroups A, C, W, Y vaccine (MenACWY) -Menveo, Menactra, or MenQuadfi. These require booster shots every 5 years.
    Date of last vaccination: _____
    b. Meningococcal serogroup B vaccine -Bexsero or Trumenba. These require booster shots 1 year after primary series and every 2 to 3 years thereafter.
    Date of last vaccination: _____

    Documentation for vaccines must be sent with the order.
    Patients not vaccinated should be on prophylaxis antibiotics until vaccines are up to date. Patients who have been vaccinated less than 2 weeks prior to start of infusion should be on 2 weeks of antibacterial prophylaxis.
4. Treatment should be administered at the recommended time interval although administration may vary by ±2 days.
5. Monitoring during therapy: monitor platelet count, serum LDH levels, and serum creatinine levels during therapy. Monitor for signs and symptoms of infection, in particular meningococcal infections.
6. Monitoring after discontinuation:
    a. Atypical hemolytic uremic syndrome (aHUS) patients who discontinue treatment should be monitored closely for at least 12 weeks for signs and symptoms of thrombotic microangiopathy (TMA) complications.
    b. Paroxysmal nocturnal hemoglobinuria (PNH) patients who discontinue treatment should be monitored for at least 8 weeks for signs and symptoms of hemolysis
7. Consider penicillin prophylaxis for the duration of eculizumab therapy to potentially reduce the risk of meningococcal disease.

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PRE-SCREENING: (Must be available prior to initiation of therapy):

- Meningococcal serogroups A, C, W, Y vaccine (MenACWY) -MenQuadfi, Menactra, or Menveo given on (dates) _____
- Meningococcal serogroup B vaccine -Bexsero or Trumenba given on (dates) _____

LABS:

- ☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ LDH TOTAL, Routine, ONCE every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: _____

NURSING ORDERS:

1. Vital signs at baseline, post-infusion, and prior to discharge.
2. Monitor for 1 hour after infusion complete for signs or symptoms of infusion reaction. May discontinue observation if stable and tolerating infusions.
3. Hold treatment and notify provider if patient is not up to date on meningococcal vaccination every 5 years for MenACWY (Menveo, Menactra, or MenQuadfi) or 1 year after primary series and every 2 to 3 years thereafter for MenB (either Bexsero or Trumenba).
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

Atypical hemolytic uremic syndrome (aHUS), Generalized myasthenia gravis, refractory, or Neuromyelitis optica spectrum disorder

☐ **Initial doses**: eculizumab (SOLIRIS) 900 mg in sodium chloride 0.9% 90 mL, intravenous, ONCE Every week x 4 doses

☐ **Maintenance doses**: eculizumab (SOLIRIS) 1200 mg in sodium chloride 0.9% 120 mL, intravenous, ONCE Every 2 weeks x _____ doses, begin on week 5

Infuse over 35 minutes. Infusion may be slowed or stopped due to adverse reactions but should be finished within 2 hours
Provide patient with Soliris Patient Safety Card to keep at all times

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Paroxysmal nocturnal hemoglobinuria (PNH)

☐ **Initial doses**: eculizumab (SOLIRIS) 600 mg in NaCl 0.9% 60 mL, intravenous, ONCE
Every week x 4 doses

☐ **Maintenance doses**: eculizumab (SOLIRIS) 900 mg in NaCl 0.9% 90 mL, intravenous, ONCE
Every 2 weeks x _____ doses, begin on week 5

Infuse over 35 minutes. Infusion may be slowed or stopped due to adverse reactions but should be finished within 2 hours
Provide patient with Soliris Patient Safety Card to keep at all times

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

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Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders