### 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 OneSource Safety Support Program.
   - b. Patient enrollment is voluntary. Provide patient with Soliris Patient Safety Card to carry with them at all times.
   - c. Please see reference links below for enrollment forms and additional help
      - ii. [http://www.solirisrems.com/docs/1ALSO051_HCP-Enroll-form_M05.pdf](http://www.solirisrems.com/docs/1ALSO051_HCP-Enroll-form_M05.pdf)
      - iii. [http://www.solirisrems.com/docs/1ALSO051_Patient-Enroll-form_M04.pdf](http://www.solirisrems.com/docs/1ALSO051_Patient-Enroll-form_M04.pdf)
3. Patients must receive meningococcal vaccine at least 2 weeks prior to treatment initiation; revaccinate according to current guidelines.
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

### PRE-SCREENING: (Must be given 2 weeks prior to initiation of therapy):
- Meningococcal polysaccharide vaccine given on (date) ________________

### LABS:
- □ CBC with differential, Routine, ONCE, every ______ (visit)(days)(weeks)(months) – Circle One
- □ CMP, Routine, ONCE, every ______ (visit)(days)(weeks)(months) – Circle One
- □ Urine, Microscopic Exam, Routine, ONCE, every ______ (visit)(days)(weeks)(months) – Circle One
- □ Labs already drawn. Date: __________
PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

1. acetaminophen (TYLENOL) tablet, oral, ONCE, every visit
   - 650 mg
   - 325 mg
   - 500 mg
   - 1000 mg

2. diphenhydramINE (BENADRYL) capsule, oral, ONCE, every visit
   - 25 mg
   - 50 mg

3. loratadine (CLARITIN) tablet, oral, ONCE, every visit
   (Choose as alternative to diphenhydramINE if needed)
   - 5 mg
   - 10 mg

4. famotidine (PEPCID), intravenous, ONCE, every visit
   - 20 mg

MEDICATIONS:

**Atypical hemolytic uremic syndrome (aHUS)**

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

- **Maintenance doses**: eculizumab (SOLIRIS) 1200 mg in NaCl 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

**HIGH ALERT MEDICATION** Provide patient with Soliris Patient Safety Card to keep at all times

**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

**HIGH ALERT MEDICATION** Provide patient with Soliris Patient Safety Card to keep at all times
NURSING ORDERS:
1. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and every 15 minutes throughout infusion.
2. Observe for 1 hour after infusion complete (Unless the prescriber indicates this is not necessary).
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

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 (Policy HC-PAT-133-GUD). 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 x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x1 dose for hypersensitivity 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: ____________________________
OLC Central Intake Nurse:

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