Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Eculizumab (SOLIRIS)

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 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
        i. http://www.solirisrems.com/
        ii. http://www.solirisrems.com/docs/1ALSO051_HCP-Enroll-form_M05.pdf
        iii. http://www.solirisrems.com/docs/1ALSO051_Patient-Enroll-form_M04.pdf
        iv. http://www.solirisrems.com/docs/1ALSO050_SafetyCard_D02_CS4.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: _____

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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

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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 x 1 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**: _____

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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