ECULIZUMAB (Soliris) Infusion Order Form

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine

Original ordering provider must be enrolled in REMS program https://www.ultsolrems.com/

Weight: _____kg Height: _____inches

[ ] New treatment
[ ] Transfer - Start on week #_____

PRIOR TO FIRST DOSE:

Verify meningococcal vaccine completed at least 14 days prior to start date.#

Note: Do not use combined ABCWY vaccine as full immune effect delayed for 6 months.

- Meningococcal conjugate (MenACWY) vaccine
  0.5 ml IM x 2 doses at least 8 weeks apart **Date complete**_____
  Booster 0.5 ml IM x1 every 5 years.*
- Meningococcal group B (MenB) vaccine
  0.5 ml IM x 2 doses at least 4 weeks apart **Date complete**_____
  Booster 0.5 ml IM once year after series complete, then every 2 to 3 years.*

* Note dates booster dose due in clinic record.

If less than 2 weeks since full meningococcal vaccination, verify patient is on prophylactic anti-infective for the first 2 weeks of therapy. Consider antimicrobial prophylaxis with oral antibiotics for the duration of therapy.

Antimicrobial therapy ordered if any:_____

PRIOR TO EACH INFUSION

See page 2 for labs, nursing assessment, vital signs, administration and observation times

PRE-MEDICATE (30 minutes before infusion):

[ ] acetaminophen _____ mg PO
[ ] loratadine 10 mg PO
[ ] diphenhydramine _____ mg PO
[ ] methylprednisolone _____ mg IV
[ ] diphenhydramine _____ mg IV

DOSE (select diagnosis): Administer within 2 days of the recommended interval.

[ ] **Myasthenia Gravis**-*AChR positive*
[ ] **Neuromyelitis optica-** *aquaporin-4-antibody positive*
[ ] **Atypical hemolytic uremic syndrome**
Eculizumab 900 mg IV weekly x 4 weeks, 1200 mg IV week 5, then continue 1200 mg IV every 2 weeks

[ ] **Paroxysmal Nocturnal Hemoglobinuria (PNH)**
Eculizumab 600 mg IV weekly x 4 weeks, 900 mg IV week 5 then continue 900 mg IV every 2 weeks

[ ] Other:_____

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Duration of authorization:_____

Checklist for non-RFGH credentialed providers:

[ ] Problem list, current medication and allergies attached
[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, call (207) 474-5121 and ask to speak to hospitalist .
Contacted provider:_____

FAX RFGH Infusion clinic at 207-858-2404 **Contact Infusion Clinic at 207-858-8722**

Revised 7/8/25

Provider signature _____Date_____time_____
If not RFGH credentialed:

Printed name_____ NPI # _____ (required)

RFGH Co-signature _____

Date_____ time:_____

Patient name_____
Date of birth_____
Patient phone number_____

PRIOR TO EACH INFUSION:

- CBC with differential, lactic dehydrogenase (LDH), serum creatinine, AST, Urinalysis – culture if indicated before each treatment
- Supply patient with the manufacturer/FDA Medication Guide and medication safety card.
- Instruct patient of signs of infusion type reaction and to immediately report chest pain, trouble breathing, or swelling of face, tongue, or throat.
- Assess for infection; delay administration for active infection.

INFUSION

- Vital signs prior to infusion and every 15 minutes.
- Infuse over 35 minutes. Decrease infusion rate or discontinue for infusion reactions;
- Do not exceed a maximum 2-hour duration of infusion in adults.
- Observe patient for 1 hour after infusion.

Revised: 4/8/25
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