

Eculizumab (Soliris®) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code(s): _____

Meningococcal Vaccination Status:

Primary vaccination series completed – date: _____

MenACWY booster completed – date: _____

MenB booster completed – date: _____

Eculizumab (Soliris®) Prescription

Eculizumab (Soliris®) refill as directed x 1 year

Induction Dose:

Infuse 600 mg IV over at least 35 min weekly x 4 weeks.

Infuse 900 mg IV over at least 35 min weekly x 4 weeks.

Other: _____

Maintenance Dose:

Infuse 900 mg IV over at least 35 min on Week 5, then every 2 weeks thereafter.

Infuse 1200 mg IV over at least 35 min on Week 5, then every 2 weeks thereafter.

Infuse _____ mg IV over at least 35 min every 2 weeks.

Other: _____

Max infusion time not to exceed 2 hours.

Ancillary Orders

Anaphylaxis Kit

Treat per Froedtert Home and Specialty Infusion protocol.

Medication Orders

Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.

Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.

Other: _____

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab draw.

Lab Orders

No labs ordered at this time.

Other: _____

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
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