McLeod Health

Place Sticker Here

Eculizumab (Soliris) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one):

□ D59.5 Paroxysmal Nocturnal Hemoglobinuria □ D59.3 Atypical Hemolytic Uremic Syndrome

□ Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

□ None ***(product information does not suggest any pre-medication prior to infusion)***

□ Acetaminophen 650 mg PO

□ Diphenhydramine: Dose: □ 25 mg □ 50 mg Route: □ PO or □ IVP

□ Methylprednisolone: Dose: □ 40 mg or □ 125 mg Route: IVP

□ Famotidine: Dose: 20 mg Route: □ PO or □ IVPB

Drug Orders (select appropriate dosing and frequency):

• Eculizumab (Soliris) (J1300) IV diluted in Sodium Chloride 0.9% to a 5 mg/mL concentration infused over a minimum of 35 minutes. Each infusion will be followed with a 1 hour monitoring period.

□ Dosing/Frequency for PNH: □ Induction: 600 mg once weekly Weeks 1-4, followed by 900 mg once weekly Week 5

□ Maintenance: 900 mg once every 2 weeks

□ Dosing/Frequency for aHUS: □ Induction: 900 mg once weekly Weeks 1-4, followed by 1200 mg once weekly Week 5

□ Maintenance: 1200 mg once every 2 weeks

• Order Duration: Six months unless otherwise specified (Other: _____)

Lab Orders:

□ _____

Standing Orders:

• Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

● Documented meningococcal vaccination administration (at least 2 weeks prior to start of therapy)

● Documented prescriber enrollment in the Soliris REMS program and appropriate patient education required by REMS program

Previous Therapies:

● For new patient referrals, please send history and physical and most recent physician note with completed plan

● If patient has previously received eculizumab at another facility, please provide last date received: _____

● If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Seacoast: 843-366-2224 (Fax)

843-366-3626 (Phone)