



# MEDICATION ORDERS

## SOLIRIS (ECULIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: <input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Atypical Hemolytic Uremic Syndrome (aHUS)	ICD 10 Code: D59.3
<input type="checkbox"/> Myasthenia Gravis, Acetylcholine Receptor Antibody Positive	ICD 10 Code: G70.00
<input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5
<input type="checkbox"/> Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code: G36.0

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis)	<input type="checkbox"/> Aquaporin 4 Antibody Test Results (if NMO)
	<input type="checkbox"/> Documentation of meningococcal vaccines (include dates)
Is your patient enrolled in the UltSolREMS program? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is the ordering PROVIDER enrolled in the UltSolREMS program? <input type="checkbox"/> YES <input type="checkbox"/> NO (if no, must be enrolled to start therapy)	
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	

MEDICATION ORDERS	
Dosing for aHUS, Myasthenia Gravis, and NMO	<input type="checkbox"/> Soliris 900mg IV once weekly for 4 weeks, followed by 1200mg IV at week 5, then 1200mg IV every 2 weeks thereafter
Dosing for PNH	<input type="checkbox"/> Soliris 600mg IV once weekly for 4 weeks, followed by 900mg IV at week 5, then 900mg IV every 2 weeks thereafter
Refills: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses	
<ul style="list-style-type: none"><li>• New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.</li><li>• Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.</li></ul>	

*Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first dose of Ultomiris, unless the risks of delaying Ultomiris therapy outweigh the risk of developing a meningococcal infection. For patients who are not up to date with meningococcal vaccines at least two weeks prior to initiation of treatment and who must start ULTOMIRIS or SOLIRIS urgently: Provide the patient with a prescription for antibacterial drug prophylaxis. Comply with the most current National Advisory Committee on Immunization (NACI) recommendations for meningococcal vaccination in patients with complement deficiencies.*

PREMEDICATIONS
<input checked="" type="checkbox"/> Acetaminophen 1000mg PO, 30 minutes prior to infusion
<input checked="" type="checkbox"/> Diphenhydramine 25mg IVP, 30 minutes prior to infusion
<input type="checkbox"/> Other: _____

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:		Office Fax Number:	
Physician Signature:		Date:	

**Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000**  
Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207