MONTGOMERY CANCER CENTER
A BAPTIST MEDICAL CENTER SOUTH FACILITY

MEDICATION ORDERS

SOLIRIS (ECULIZUMAB)

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

REFERRAL STATUS
❑ New Referral ❑ Dose or Frequency Change ❑ Order Renewal

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: ❑ Montgomery ❑ Prattville

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

REQUIRED DOCUMENTATION/TESTING	
❑ This signed order form by the provider	❑ Clinical/Progress notes supporting primary diagnosis
❑ Patient demographics AND insurance information	❑ Labs and Tests supporting primary diagnosis
❑ Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis)	❑ Aquaporin 4 Antibody Test Results (if NMO)
	❑ Documentation of meningococcal vaccines (include dates)
Is your patient enrolled in the UltSolREMS program? ❑ YES ❑ NO	
Is the ordering PROVIDER enrolled in the UltSolREMS program? ❑ YES ❑ 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	❑ 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	❑ Soliris 600mg IV once weekly for 4 weeks, followed by 900mg IV at week 5, then 900mg IV every 2 weeks thereafter

Refills: ❑ x 6 months ❑ x 1 year ❑ _____ doses

- 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.
- 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.

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
✓ Acetaminophen 1000mg PO, 30 minutes prior to infusion
✓ Diphenhydramine 25mg IVP, 30 minutes prior to infusion
❑ 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

All information contained in this form is strictly confidential and will become part of the patient's medical record.