

MHS Home/Alternate Site Infusion Services Eculizumab (Soliris) Infusion Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name: _____ **DOB:** ____/____/____ **Weight:** _____ lb/kg

Patient Phone Number: (____) ____-____ **Requested Date of Service:** ____/____/____

Patient Allergies: _____

Diagnosis: _____ **ICD – 10 Code:** _____

- Z45.2: Encounter for adjustment and management of vascular access device
- Z95.828: Presence of other vascular implants and grafts

Baseline Labs: none required

Baseline Vaccination (Required): Meningococcal vaccine at least 2 weeks prior to administering initial dose of Eculizumab (Soliris)
Date given: ____/____/____

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **Patient must be enrolled in Eculizumab (Soliris) REMS program before starting. ** Emergency phone number for provider _____ (required) ****

Provider Order for Eculizumab (Soliris) Infusion

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Pre-Medication(s):

None recommended

Biologic Infusion:

Eculizumab (Soliris)

- Atypical Hemolytic Uremic Syndrome (AHUS) Myasthenia gravis (MG)
- Neuromyelitis Optica Spectrum Disorder (NOSD) Paroxysmal Nocturnal Hemoglobinuria (PNH)

AHUS/MG/NOSD: 900 mg weekly x4 doses; then 1200 mg at week 5; then 1200 mg every 2 weeks

PNH: 600 mg weekly x4 doses; then 900 mg at week 5; then 900 mg every 2 weeks

Loading Dose: Infuse _____ mg via infusion pump over 35 min

Maintenance Dose: Infuse _____ mg via infusion pump over 35 min

Infusion and Dilution Recommendations

Dose (mg)	NS to add	Total Volume	Infusion time
600 mg	60 mL	120 mL	35 min
900 mg	90 mL	180 mL	35 min
1200 mg	120 mL	240 mL	35 min

Additional Medications for vascular access maintenance:

- 0.9% NaCl (NS) PF flush in 10 mL syringe: Administer 5 – 30 mL IV as needed for establishing and maintaining IV access and for flushing IV line post infusion.
- Heparin: 100 units/mL for port OR 10 units/mL for other central line/midline, 3-5 mL PRN for de-accessing line.
- Cathflo (alteplase) 2 mg: Instill 2 mg (2 mL) into occluded catheter as needed for CVC/CVAD occlusion.

Skilled Nurse to draw labs as follows:

- Lab(s): _____ Frequency: _____

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FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:

Name:
MRN:
DOB:

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Skilled Nurse Interventions:

- Admit (first visit) patient to services for home infusion therapy of Eculizumab (Soliris).
- Complete Skilled Nurse visit with each infusion for ongoing home infusion therapy of Eculizumab (Soliris).
- Obtain vital signs (TPR & B/P) at baseline and at completion of infusion.
- Obtain patient weight at each visit.
- Establish IV access and flush per policy to maintain patency.
- Draw labs as ordered.
- Add Eculizumab (Soliris) to recommended volume of Normal Saline 0.9% (see page 1).
- Infuse Eculizumab (Soliris) as prescribed.
- Once infusion complete, flush IV line with Normal Saline 0.9% as prescribed.
- If vital signs are stable after infusion, Skilled Nurse will discontinue IV access and complete visit.

If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):

The Skilled Nurse will:

- STOP THE INFUSION.
- Administer emergency medications as prescribed (below).
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: Yes No (if yes, please send DOCUMENTATION of consent with order)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ Printed Name: _____ Date: _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:

Address: _____

Phone #: _____ Fax#: _____

Return completed orders to:

MultiCare Home/Alternate Infusion Services
253-459-6650 (phone) / 253-864-2785 (fax)

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:

Name:
MRN:
DOB:

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