

**ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN**

**Allergies/Reactions:**

Fax all infusions to: 833-380-8800  
Please mark the appropriate infusion center:

- |   |   |
|---|---|
| <input type="checkbox"/> Allenmore Infusion Center    | <input type="checkbox"/> DHEC Infusion Center             |
| <input type="checkbox"/> Auburn Infusion Center       | <input type="checkbox"/> North Spokane Infusion Center    |
| <input type="checkbox"/> Gig Harbor Infusion Services | <input type="checkbox"/> North Star Lodge Infusion Center |
| <input type="checkbox"/> Puyallup Infusion Center     |   |

**ORDERS WITH CHECK BOXES**

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

**Eculizumab (Soliris)**

Patient Name: \_\_\_\_\_ Requested Date of Service: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  May leave message

**Diagnosis:**

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

**ICD -10 Code:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Required:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation  
**\*\*If required documentation not received with order, scheduling of treatment will be delayed until complete information is available\*\***

**Baseline labs required:** None required

**Maintenance labs:** None required

**Baseline Vaccinatin (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 Eculizumb (Soliris) REMS program before starting.**

**IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P; Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

**Pre-meds:** Non recommended

**Treatment Regimen:**

- AHUS/MG/NOSD = 900 mg weekly x 4 doses; then 1200 mg at week 5 then 1200 mg every 2 weeks
- PNH = 600 mg weekly x 4 doses; then 900 mg at week 5 then 900 mg every 2 weeks

**Vital Signs:** Check vital signs prior to and at completion of infusion.  
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

**If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):**

- Consult MultiCare Hypersensitivity guideline for treatment/management
- Notify provider of reaction, assessment and need for further orders"

**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)

Provider Signature

Print Name

Date

Time

**Orders expire in 12 months\*\***

**Patient Identification - Always Attach Patient Label**

Name:  
MRN #:  
CSN #:  
Age / Sex and Gender:

Pre-printed Order

**AHUS / MG / NOSD / PNH**

**MultiCare** 



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