

## 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

**Lab Orders:** \_\_\_\_\_

**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.

**Biologic Infusion:**

Eculizumab (Soliris)

- |  |  |
|--|--|
| <input type="checkbox"/> Atypical Hemolytic Uremic Syndrome (AHUS)     | <input type="checkbox"/> Myasthenia gravis (MG)                    |
| <input type="checkbox"/> Neuromyelitis Optica Spectrum Disorder (NOSD) | <input type="checkbox"/> 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:**

- 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.
- Diphenhydramine 25 mg IV once, as needed for itching.
- Acetaminophen 325-650 mg tab/cap by mouth once, as needed for pain.

CONTINUED ON NEXT PAGE

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).
- For mild infusion reaction, may restart the infusion at a slower rate (verified with pharmacist) if symptoms resolve with medication.
- 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. Max dose = 50 mg.
- **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 Site 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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