ECULIZUMAB (*Soliris, BKEMV*) Infusion Order

sage infusion

intake@sageinfusion.com | www.sageinfusion.com/SubmitOrder

PATIENT INFORMATION

Patient Name: _____ **DOB**: _____ **Gender:** ☐ M ☐ F

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone: _____ **Email:** _____ **Ht:** _____ **Wt:** _____

Please Attach: ☐ Insurance cards ☐ History & Physical ☐ Most recent labs ☐ Medication list

☐ **NKDA** ☐ **Allergies:** _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____

Practice Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

REQUIRED INFORMATION

Documentation:

☐ Recent clinical and/or office visit notes supporting primary diagnosis
☐ Meningococcal vaccination (both conjugate and serogroup B) are required prior to initiating Soliris infusions (please attach)
☐ For generalized myasthenia gravis patients specifically, anti-acetylcholine receptor (AChR) antibody positive status must be confirmed.

MEDICATION ORDERS

ICD-10 codes applicable for either medication (Soliris or BKEMV)

☐ **G70.00** Myasthenia gravis ☐ **G70.01** Myasthenia gravis w/acute exacerbation ☐ **D59.32** Hereditary hemolytic-uremic syndrome
☐ **D59.39** Other hemolytic-uremic syndrome ☐ **D59.5** Paroxysmal nocturnal hemoglobinuria ☐ **Other** _____

ICD-10 Soliris

☐ **G36.0** Neuromyelitis Optica (NMOSD) ☐ **Other** _____

☐ **New to Therapy** ☐ **Continuation of Therapy:** Date of last dose (if applicable): _____

Pre-medication:

☐ Acetaminophen1000mg PO
☐ Diphenhydramine 25mg PO
☐ Ceterizine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP

DOSING/FREQUENCY:

Induction dose:

☐ **600 mg** weekly for the first four weeks followed by **900 mg** for the fifth dose one week later, then **900 mg** two weeks later

☐ **900 mg** weekly for the first four weeks followed by **1200 mg** for the fifth dose one week later, then **1200 mg** two weeks later

Maintenance dose: ☐ **900 mg** every two weeks ☐ **1200 mg** every two weeks

☑ **Dilute with 0.95% NS to a final concentration of 5mg/ml**

(600mg doses final volume 120ml, 900mg doses final volume 180ml, 1200 mgdoses final volume 240ml) Infuse over 35 minutes in adults

☐ **Refills:** _____ *(if not indicated prescription will expire one year from date signed)*

Sage Infusion Standing Orders:

☑ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

_____ _____ _____

Provider Name | Provider Signature | Date

Fax Number

☐ **Brandon: (656) 218-9643**
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