Eculizumab (Soliris)

Provider Order Form rev. 08/06/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

generalized myasthenia gravis without exacerbation: Neuromyelitis Optica (NMOSD):

Other: Description:

REQUIRED INFORMATION

MenACWY: Date of 1st dose: _____ Brand: _____
Date of 2nd dose: _____ Brand: _____
Meb B: Date of 1st dose: _____ Brand: _____
Date of 2nd dose: _____ Brand: _____
(Trumenba only) Date of 3rd dose: _____
Prophylactic antibiotics prescribed: ☐ Yes / ☐ No
Date patient started prophylactic antibiotics *(if applicable)*: _____
Provider REMS ID: _____

☐ **For gMG diagnosis**: Patient is anti-acetylcholine receptor antibody positive (provide documentation)
☐ **For NMSOD diagnosis:** Patient is anti-aquaporin-4 (AQP4) antibody positive (provide documentation)
☐ **For gMG diagnosis:** Meningococcal vaccine(s) given on _____ date. First Soliris dose may be given at least 2 weeks later unless otherwise specified.

THERAPY ADMINISTRATION & DOSING *(Choose one)*

☐ Administer eculizumab (Soliris) 900mg weekly[1] x4 doses. Dilute with 90 ml 0.9% sodium chloride *(final volume 180 ml)* and infuse over 35 minutes.
☐ Administer eculizumab (Soliris) 1200mg for the fifth dose one week after the fourth dose (week 5), then every 2 weeks[1] thereafter. Dilute with 120 ml 0.9% sodium chloride *(final volume 240 ml)* and infuse over 35 minutes.
☑ If infusion is stopped for any reason, total infusion time should not exceed 2 hours
☑ Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion
[1]Recommended dosage time intervals; may adjust +/- 2 days if needed

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:
- Signs/symptoms of infection or meningococcal infection such as:
  - Headache with (1) fever, (2) nausea/vomiting, (3) stiff neck/back
  - Muscle aches with flu-like symptoms, fever with or without rash, confusion or photophobia

☑ Ensure patient carries and understands Patient Safety Information Card.
☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Disease status, MRI, Flow Cytometry, MG classification, MG-ADL score, EMG results
Required Labs: Anti-Ach receptor, Anti-AQP4,

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.