Provider Order Form

SOLIRIS (ECULIZUMAB)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Generalized Myasthenia Gravis (gMG) G10. _____
☐ Neuromyelitis Optica Spectrum Disorder (NMOSD) G36.0
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) D59.5
☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Soliris (Eculizumab), IV	☐ 600 mg	☐ Induction: 600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every weeks thereafter
	☐ 900 mg	☐ Maintenance: 900 mg every 4 weeks
☐ Soliris (Eculizumab), IV	☐ 900 mg	☐ Induction: 900mg IV weekly for the for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every weeks thereafter
	☐ 1200 mg	☐ Maintenance: 1200mg IV every 2 weeks

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other _____ ☐ at each dose ☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Meningococcal vaccination

_____ _____

Provider Signature Date