ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ North Spokane Infusion Center - Fax: 509-232-2531

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)
❑ Myastheynia 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

60-0350-1 (5/23)