Comanche County Memorial Hospital

Outpatient Infusion Center
Soliris Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender: ◯ M ◯ F

Patient Address: Email: Insurance:

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)
☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)
☐ G36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD)
☐ G70.00 Myasthenia Gravis (gMG) without Acute Exacerbation
☐ G70.01 Myasthenia Gravis (gMG) with Acute Exacerbation
☐ Other: DX: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs/ _____ kg ☐ Patient Height: _____ in/ _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____
☐ TB Test: Date: _____ Results: _____ ☐ Hep B Test: Date: _____ Results: _____
☐ Does the patient have a history of an adverse reaction to Soliris? Yes or No
☐ Is the patient Anti-Acetylcholine Receptor (AChR) positive? (if gMG diagnosis) Yes or No (If "yes" send the results)
☐ Is the patient Anti-Aquaporin Antibody positive? (if NMOSD diagnosis) Yes or No (If "yes" send the results)
☐ Prescriber Enrolled in Soliris REMS Program? Yes or No
☐ Patient Received Meningococcal Vaccine? Yes or No Date of vaccination: _____
☐ Does the patient have venous access? Yes or No If yes, What type? _____
If No, initiate IV access.

Lab Orders

☐ CBC w/o diff ☐ CMP ☐ ESR ☐ CRP
☐ Other: _____

Lab Orders to be done by

☐ Infusion Services
☐ Referring Provider

Prescription Information

☐ Soliris

Initial Dose:

☐ 600mg weekly for first 4 weeks; then 900mg for 5th dose 1 week later
☐ 900mg weekly for the first 4 weeks; then 1200mg for 5th dose 1 week later

Maintenance Dose:

☐ 900mg every 2 weeks after initial dose
☐ 1200mg every 2 weeks after initial dose

Misc Orders

☐ _____
☐ _____

☐ PICC/Midline/CAD dressing to be changed every 7 days

Flushes

☐ 10mL NS Flush Syringe PRN
☐ Heparin 500units/5mL Flush Syringe PRN
☐ 50ml NS Bag PRN
☐ 250ml NS Bag PRN

Standing Orders for Adverse Reaction

☐ Stop infusion and initiate NS bolus
☐ Notify Supervising physician and ordering provider
☐ Solu-Cortef 100mg SIVP signs of adverse reaction
☐ Benadryl 25 mg SIVP for hives or bronchial inflammation
☐ Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
☐ Oxygen 2-5L nasal cannula
☐ Albuterol 2.5mg inhaled PRN to chest tightness
☐ Other: _____

Prescriber Information

Physician Name: _____ Official Contact Name: _____
Contact #: _____ Fax Number: _____
Address: _____ City/State/Zip: _____
NPI#: _____ DEA#: _____ State License #: _____

_____ _____
Physician's Signature Date Time