FUSIONDRIP
HYDRATION & WELLNESS

Soliris (eculizumab) IV Infusion Order Form

Phone: 614-407-1621 Fax: 614-413-3877
orders@fusiondriphydration.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

Diagnosis (ICD-10 Selection)

☐ D59.5 – Paroxysmal nocturnal hemoglobinuria (PNH)
☐ D59.3 – Atypical hemolytic uremic syndrome (aHUS)
☐ G36.0 – Neuromyelitis optica spectrum disorder (NMOSD)
☐ G70.00 – Myasthenia gravis without acute exacerbation
☐ G70.01 – Myasthenia gravis with acute exacerbation
☐ Other: _____ **ICD-10 Code:** _____

Infusion Order

- **Induction Phase:**
  ☐ 600 mg IV weekly × 4 weeks, then 900 mg IV at Week 5
  ☐ 900 mg IV weekly × 4 weeks, then 1200 mg IV at Week 5
- **Maintenance Phase:**
  ☐ 900 mg IV every 2 weeks
  ☐ 1200 mg IV every 2 weeks
- ☐ Dilute in 0.9% sodium chloride to final concentration of 5 mg/mL
- ☐ Infuse over ≥35 minutes (max 2 hours)
- ☐ Observation: ☐ 60 minutes post-infusion
- ☐ Refills: ☐ None ☐ 12 months ☐ Other: _____

Meningococcal Vaccination

☐ Documentation of completed MenACWY and MenB series attached
☐ Patient to receive MenACWY and MenB vaccines ≥2 weeks prior to first dose
☐ Provider acknowledges patient may begin Soliris before vaccine series completion and assumes responsibility for antimicrobial prophylaxis

Line Use & Access

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard infusion protocol

Adverse Reaction & Anaphylaxis Orders

☐ Fusiondrip Hydration & Wellness Center Protocol (fusiondriphydration.com)

☐ Other – please fax preferred reaction orders to 614-413-3877

☐ **Premedication (Recommended)**
☐ Acetaminophen: ☐ 650 mg ☐ 1000 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Loratadine: ☐ 10 mg ☐ PO
☐ Methylprednisolone: ☐ 125 mg ☐ IV
☐ Hydrocortisone: ☐ 100 mg ☐ IV
☐ Other: _____ **Dose:** _____ **Route:** _____

Laboratory Monitoring

☐ CBC ☐ CMP ☐ LDH ☐ Hemoglobin
☐ Creatinine/eGFR ☐ Platelet count ☐ Anti-AChR antibody
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Each infusion ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
☐ Documentation of prior therapies or intolerance
☐ Meningococcal vaccine records

Ordering Provider & Demographics

- **Name: _____**
- **NPI: _____ License #: _____**
- **Contact: _____ Phone: _____ Fax: _____**
- **Email: _____**
- **Signature: _____ Date: ____ / _____ / _____**