PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

Northern Light Health

- ☐ NL Infusion Care, AR Gould, **Presque Isle** Phone: 207-768-4589; Fax: 207-768-4183
- ☐ NL Infusion Care, **Blue Hill** Phone: 207-374-3995; Fax: 207-374-3970
- ☐ NL Infusion Care, CA Dean, **Greenville** Phone: 207-695-5222; Fax: 207-695-4801
- ☐ NL Infusion Care, **Brewer** Phone: 207-973-9785; Fax: 207-973-9788
- ☐ NL Infusion Care, **Waterville** Phone: 207-861-3380; Fax: 207-861-3348
- ☐ NL Mary Dow Center, **Ellsworth** Phone: 207-664-5584; Fax: 207-664-5485
- ☐ NL Infusion Care, Mayo, **Dover-Foxcroft** Phone: 207-564-4254; Fax: 207-564-4418
- ☐ NL Mercy Cancer Care, **Portland** Phone: 207-553-6868; Fax: 207-904-0917
- ☐ NL Infusion Care, SVH, **Pittsfield** Phone: 207-487-4052; Fax: 207-487-3995

Outpatient Eculizumab (Soliris) Orders

DIAGNOSIS: ☐ Atypical Hemolytic Uremic Syndrome **ICD10:** ______________________________

☐ Paroxysmal Nocturnal Hemoglobinuria

☐ Myasthenia Gravis: *Positive AChR antibody test on: (Date)* _____/_____/_____

☐ Neuromyelitis Optica Spectrum Disorder: *Positive AQP4-IgG test on: (Date)* _____/_____/_____

☐ Other: ______________________________

IV ACCESS

☐ Saline Lock:

- ☑ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
- ☑ Discontinue Saline Lock after therapy completed

☐ PICC Line:

- ☑ Routine PICC Line Care, labs and restoration
- ☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)

☐ Porta cath / Central Access Device (Hickman, Triple lumen):

- ☑ Porta cath access, labs, restoration and de-access / Central Access Device use and care

Height: ____________________ *cm* **Weight:** ____________________ *kg*

REMS Enrollment

☑ Prescriber/Soliris REMS Enrollment

Done: Yes ☐ *(Date)* _____/_____/_____

No ☐

☑ **Faxed to** appropriate Infusion Center *(Date)* _____/_____/_____

☑ Patient has been counseled on REMS program

☑ Patient has received Patient Safety Brochure and Patient Safety Card

☑ Patient is enrolled in OneSource enrollment Program

Patient Signature Required: ______________________________

VACCINES / PROPHYLAXIS

☐ Patient has received meningococcal conjugate A, C, W, Y (Menveo or Menactra) on: *(Date)* _____/_____/_____

☐ Patient has received meningococcal conjugate group B (Bexsero) on: *(Date)* _____/_____/_____

OR

☐ Patient has been given a 2-week supply of antibiotic prophylaxis

OR

☐ Administer meningococcal A, C, W, Y (Menveo) *0.5 mL, IM, ONCE, at least 2 weeks prior to initiation of Soliris*

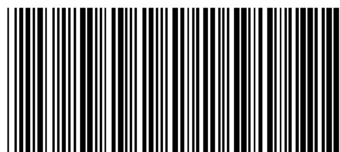
☐ Administer meningococcal A, C, W, Y (Menveo) *0.5 mL, IM, ONCE, at least 2 months after first dose of Menveo*

AND

☐ Administer meningococcal conjugate group B (Bexsero) *0.5 mL, IM, ONCE, at least 2 weeks prior to initiation of Soliris*

☐ Administer meningococcal conjugate group B (Bexsero) *0.5 mL, IM, ONCE, at least 4 weeks after first dose of Bexsero*

*NOTE: booster vaccination will need to be ordered separately. Please follow the most up to date ACIP recommendations.



Date: ______________________ Time: ______________________

Provider Signature: ______________________ Print Name: ______________________

Phone: ______________________ Fax: ______________________

Pharmacy Signature: ______________________

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS