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

OP eculizumab (Soliris) (Paper)

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.

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Date: _____ Time: _____
Provider Signature: _____ Print Name: _____
Phone: _____ Fax: _____
Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS

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OP eculizumab (Soliris) (Paper)

MEDICATION

For all indications EXCEPT Paroxysmal Nocturnal Hemoglobinuria

☐ eculizumab (Solaris) *900 mg IVPB, Every 7 Days, 4 Doses/Times*

Then at week 5:

☐ eculizumab (Solaris) *1200 mg IVPB, ONCE*

Then:

☐ eculizumab (Solaris) *1200 mg IVPB, Every 14 Days*

Duration: ☐ 6 months ☐ 1 year

For Paroxysmal Nocturnal Hemoglobinuria

☐ eculizumab (Solaris) *600 mg IVPB, Every 7 Days, 4 Doses/Times*

Then at week 5:

☐ eculizumab (Solaris) *900 mg IVPB, ONCE*

Then:

☐ eculizumab (Solaris) *900 mg IVPB, Every 14 days*

Duration: ☐ 6 months ☐ 1 year

OTHER: _____

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Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS