ECULIZUMAB

(Including Soliris or biosimilars: Epysqli, Bkemv)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

• Is referring provider enrolled in FDA REMS program? ☐ Y ☐ N

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ D59.32 Hereditary hemolytic-uremic syndrome
☐ D59.39 Other hemolytic-uremic syndrome
☐ D59.5 Paraxysmal Nocturnal Hemoglobinuria (PNH)
☐ G36.0 Neuromyelitis optica [Devic]
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Eculizumab
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

• Has the patient completed the full meningococcal vaccination series? ☐ Y ☐ N
• If no, the patient will receive first dose of Soliris at least two weeks after the first dose of the vaccine series. If you want to hold Soliris treatment until the patient has completed the full vaccine series, check here ☐

*Prophylactic antibiotic coverage is recommended if starting Soliris prior to completion of the vaccine series. This is at the discretion of, and managed by, the referring provider.
*Soliris or biosimilar (Epysqli, Bkemv) may be used according to payer guidelines. To prohibit auto-substitution, please indicate specific brand required _____

Generalized Myasthenia Gravis (gMG) – or – Atypical Hemolytic Uremic Syndrome (aHUS)
☐ Eculizumab 900 mg IV every week x 4 doses, then 1200mg IV every 2 weeks starting at week 5
☐ Eculizumab_____mg IV every_____weeks

Paroxysmal Nocturnal Hemoglobinuria (PNH)
☐ Eculizumab 600mg IV every week x 4 doses, then 900mg IV every 2 weeks starting at week 5
☐ Eculizumab_____mg IV every_____weeks

☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI and License:	☐ Email:

Provider Signature _____ Date _____

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