Eculizumab (Soliris)

Provider Order Form rev. 3/25/2022

IVX HEALTH

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVX Standard Nursing Procedures, including reaction management and post-procedure observation

☑ Meningococcal vaccination (both conjugate and serogroup B) are required prior to initiating Soliris infusions.

☐ Check here if patient has already received vaccines. Fax or attach documentation of administered vaccines.

☐ Check here for IVX to administer vaccines as outlined below.

MENINGITIS VACCINE - Patients are required to receive first dose of both the Conjugate and serogroup b vaccines prior to initiating soliris infusions.

Unless otherwise noted, vaccines will be given 2 weeks prior to starting Soliris infusion. IVX will schedule the patient for vaccine visit followed by Soliris two weeks later. If **urgent** Soliris therapy is indicated in an unvaccinated patient, IVX Health will administer meningococcal vaccine(s) as soon as possible including same day as Soliris infusion. Additionally, provider **must prescribe** patients with 2 weeks of antibacterial drug prophylaxis.

☐ Check here if this is an **urgent** start.

IVX WILL ADMINISTER BOTH VACCINES AS OUTLINED BELOW.

Meningococcal conjugate (MenACWY) vaccine

(Patient will be given either Menactra or Menveo vaccine based on availability and will receive **two doses separate by at least eight weeks**. Menactra and Menveo are not interchangeable and patient will receive same product for all doses in a series.)

Serogroup B Meningococcal (MenB) vaccine

(Patient will be given Bexsero or Trumenba vaccine based on availability and will receive either the two-dose series Bexsero at least one month apart or three-dose series Trumenba at 0, 1-2, and 6 months. Bexsero and Trumenba are not interchangeable and patient will receive same product for all doses in a series.)

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____

Dose: _____ Route: _____

Frequency: _____

THERAPY ADMINISTRATION

☑ **Eculizumab** (Soliris) in 0.9% sodium chloride, intravenous infusion

- Dose: Induction: (Choose one. If patient has already completed induction dose, proceed to maintenance dose.)
  - ☐ 600mg weekly for the first four weeks followed by 900mg for the fifth dose one week later, then 900mg two weeks later
  - ☐ 900mg weekly for the first four weeks followed by 1200mg for the fifth dose one week later, then 1200mg two weeks later
- Dose: Maintenance: (Choose one)
  ☐ 900mg every two weeks ☐ 1200mg every two weeks
- Dilute with 0.9% NS to a final concentration of 5mg/ml. (300mg doses final volume 60ml, 600mg doses final volume 120ml, 900mg doses final volume 180ml, 1200mg doses final volume 240ml.)
- Infuse over 35 minutes in adults and 1-4 hours in pediatric patients
- ☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 60-minute observation period

☐ Patient is NOT required to stay for observation time

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

Monitor the patient for at least one hour following completion of the infusion for signs or symptoms of an infusion reaction.

Ordering Provider: Initial here _____ and proceed to the next page.

PRN MEDICATIONS

(GIVEN BASED ON PATIENT ASSESSMENT)

- ☑ acetaminophen (Tylenol) 650mg PO every 6 hours for **mild** pain or fever (alternate with ibuprofen)
- ☑ ibuprofen (Advil) 400mg PO every 4 hours for **mild** pain or fever (alternate with acetaminophen)
- ☑ ketorolac (Toradol) 30mg SIVP x 1 for **moderate to severe** pain/headache (Do not give with elevated creatinine. If pain/headache not relieved 15-20 minutes after administration notify provider. Consider stopping infusion and transfer to an acute care setting.)
- ☑ diphenhydramine (Benadryl) 25-50mg PO every 4 hours for **mild** itching or hives
- ☑ hydroxyzine 50mg PO every 12 hours for **mild** itching or hives (consider if diphenhydramine already given)
- ☑ diphenhydramine 25-50mg SIVP, for **severe** itching, rash, or shortness of breath. May repeat 25-50mg SIVP x 1
- ☑ ondansetron (Zofran) 4mg SIVP every 4-6 hours for nausea/vomiting, may repeat 4mg SIVP x1 for a max dose of 8mg

HYPERTENSION MANAGEMENT

SBP > 30mmhg above baseline or SBP > or = 160

- ☑ clonidine 0.1mg PO x 1

SBP > 40mmhg above baseline or BP > or = 170/100 Notify provider and repeat VS q 5 minutes

- ☑ hydralazine 10mg SIVP over 2-3 minutes, may repeat dose x 1 in 20 minutes (Do not give if heart rate >100 BPM)

SPECIAL INSTRUCTIONS

INFUSION/MONITORING PARAMETERS

- ☑ **If any of the following below are present, stop infusion, monitor vital signs every 5 minutes and notify provider.**
- ☑ **If blood pressure remains >40mmhg above baseline or ≥ 170/100 after administration of PRN medications.**
- ☑ **If chest pain, pressure or tightness that is not relieved with PRN medication administration.**
- ☑ **If heart rate < 50 or > 110 and patient symptomatic; dizziness, shortness of breath, chest pain, pressure or discomfort.**
- ☑ **If SPO2 < 92% with or without supplemental oxygen.**
- ☑ **Any sudden onset or change in neurological symptoms.**

*Premedicate patients with high dose corticosteroids (1,000 mg methylprednisolone or equivalent) immediately prior to LEMTRADA infusion and for the first 3 days of each treatment course.

*Administer anti-viral prophylaxis for herpetic viral infections starting on the first day of each treatment course and continue for a minimum of two months following treatment with LEMTRADA or until the CD4+ lymphocyte count is at least 200 cells per microliter, whichever occurs later.

*Observe patients for infusion reactions during and for at least 2 hours after each LEMTRADA infusion.

*Conduct the following laboratory tests at baseline and at periodic intervals until 48 months after the last treatment course of LEMTRADA in order to monitor for early signs of potentially serious adverse effects:

- Complete blood count (CBC) with differential (prior to treatment initiation and at monthly intervals thereafter)
- Serum creatinine levels (prior to treatment initiation and at monthly intervals thereafter)
- Urinalysis with urine cell counts (prior to treatment initiation and at monthly intervals thereafter)
- A test of thyroid function, such as thyroid stimulating hormone (TSH) level (prior to treatment initiation and every 3 months thereafter)
- Serum transaminases (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) and total bilirubin levels (prior to treatment initiation and periodically thereafter)

***Providers choosing to refer patients for Lemtrada infusions must complete this order set. Outside order sets will not be accepted. Please direct any questions or comments regarding the use of this order set to Matt Munden, RN Director of Nursing or Andrew Lasher, MD Chief Medical Officer.**

Provider Name (Print) | **Provider Signature** | **Date**

FAX NUMBERS

☐ CHICAGO: 312-253-7244	☐ INDIANAPOLIS: 844-983-2028	☐ PHILADELPHIA: 844-820-9641	☐ WEST TN/AR: 888-615-1445
☐ COLUMBUS: 844-627-2675	☐ JACKSONVILLE: 904-212-2338	☐ RALEIGH: 919-287-2551	☐ MIDDLE TN: 888-615-1445
☐ BAY AREA: 844-889-0275	☐ DAYTONA: 386-259-6096	☐ KANSAS CITY: 844-900-1292	☐ SARASOTA: 941-870-6550	☐ EAST TN: 615-425-7427
☐ CHARLOTTE: 336-663-0143	☐ HARRISBURG: 844-859-4235	☐ ORLANDO: 844-946-0867	☐ SOUTHWEST FL: 813-283-9144	
☐ CINCINNATI: 844-946-0868	☐ HARTFORD: 860-955-1532	☐ PALM BEACH: 561-768-9044	☐ TAMPA: 844-946-0849	