Eculizumab (Soliris) p1

Provider Order Form *rev. 2/11/25*

IVX HEALTH

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

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

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

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 Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 05.01.2023)

MENINGOCOCCAL VACCINATION

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 separated by at least eight weeks. Menactra and Menveo are not interchangeable. The patient will receive the 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 a three-dose series at 0, 1-2, and 6 months. Bexsero and Trumenba are not interchangeable. The patient will receive the same product for all doses in a series.)

Please select the preferred therapy plan to be administered by IVX:

☐ Check here if patient has already completed the meningococcal vaccination series for MenACWY and MenB. Fax or attach documentation of administered vaccines.
MenACWY (brand and dates): _____
MenB: _____

☐ Patient is to receive first doses of MenACWY and MenB vaccines 2 weeks prior to starting Soliris. IVX will schedule the patient for a vaccination visit followed by Soliris two weeks later.*

**By selecting this option, the prescribing provider is aware and acknowledges that the patient will begin Soliris before the completion of the meningococcal vaccination series. The decision to prescribe concomitant antimicrobial therapy is the responsibility of the prescribing provider. IVX Health clinicians will not prescribe antimicrobial therapy.*

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, IV 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
☐ 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.

Continue to next page.

Eculizumab (Soliris) P2

Provider Order Form *rev. 2/11/25*

Date: Patient Name: DOB:

SPECIAL INSTRUCTIONS

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

FAX NUMBERS	☐ COLUMBUS: 844-627-2675	☐ HARRISBURG: 844-859-4235	☐ MIAMI: 786-744-5687	☐ PIEDMONT TRIAD: 336-790-2200
☐ ARKANSAS: 501-451-5644	☐ CONNECTICUT: 860-955-1532	☐ HOUSTON: 832-631-9595	☐ MIDDLE/WEST TN: 888-615-1445	☐ RALEIGH: 919-287-2551
☐ AUSTIN: 512-772-2824	☐ DALLAS: 469-947-6114	☐ INDIANAPOLIS: 844-983-2028	☐ NORTH CENTRAL FL: 352-756-4191	☐ SAN ANTONIO: 726-238-9950
☐ BAY AREA: 844-889-0275	☐ DAYTONA: 386-259-6096	☐ JACKSONVILLE: 904-212-2338	☐ NORTH JERSEY: 551-227-2823	☐ SARASOTA: 941-870-6550
☐ CHARLOTTE: 336-663-0143	☐ DELAWARE: 302-596-8553	☐ KANSAS CITY: 844-900-1292	☐ ORLANDO: 844-946-0867	☐ SOUTH JERSEY: 856-519-5309
☐ CHICAGO: 312-253-7244	☐ EAST TN/TRI-CITIES: 615-425-7427	☐ LAKELAND: 863-316-3910	☐ PALM BEACH: 561-768-9044	☐ SOUTHWEST FL: 813-283-9144
☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ MELBOURNE: 321-800-9515	☐ PHILADELPHIA: 844-820-9641	☐ TAMPA: 844-946-0849