BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

SOLIRIS (ECULIZUMAB) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

☐ Atypical Hemolytic Uremic Syndrome (aHUS) ICD-10 Code: _____

☐ Myasthenia Gravis (gMG) ICD-10 Code: _____

☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) ICD-10 Code: _____

☐ Neuromyelitis Optica Spectrum Disorder (NMOSD) ICD-10 Code: _____

☐ Diagnosis: _____ ICD-10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ H&P and Clinical/Progress notes supporting primary diagnosis

☐ Labs and Tests supporting primary diagnosis

☐ Antibody results (if applicable): Anti-AQP4 for NMOSD, AChR for gMG

☐ Documentation of meningococcal vaccines

Is the ordering PROVIDER enrolled in the Ultomiris and Soliris REMS program? ☐ Yes ☐ No (must be enrolled to start therapy)

Is your patient enrolled in the Soliris REMS program? ☐ Yes ☐ No (must be enrolled to start therapy)

List tried & failed therapies:

1)

2)

MEDICATION ORDERS

Loading Dose	☐ Soliris _____mg IV once weekly for 4 weeks, followed by _____mg IV at week 5 and every 2 weeks thereafter ☐ Soliris _____mg once weekly for _____weeks, followed by _____mg IV at week _____
Maintenance Dose	☐ Soliris _____mg IV every 2 weeks ☐ Soliris_____mg IV every _____weeks

Refills*: ☐ X 6 months ☐ X 1 Year ☐ _____ doses ☐ Other: _____

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

☐ RN to flush and lock VAD/CVAD per company protocol

Other: _____

PREMEDICATION ORDERS

☐ Acetaminophen 650mg PO prior to infusion ☐ Other: _____

☐ Diphenhydramine 25mg PO prior to infusion ☐ Other: _____

EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

REV: 6/2025

Helena, MT
Phone: (406) 430-1265
Fax: (406) 752-0443

Kalispell, MT
Phone: (406) 752-0440
Fax: (406) 752-0443