Ascension St. Vincent's

Outpatient infusion center
Phone 904-296-5994 Fax 904-296-9070

Patient Name: _____
Date of Birth: _____
Patient Phone number: _____
Insurance: _____
Subscriber ID: _____
Infusion Site: _____

Eculizumab(Soliris, Epysqli, Bkemv) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information						
Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List:_____

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐Atypical hemolytic uremic syndrome ☐Myasthenia gravis, generalized ☐Neuromyelitis optica spectrum disorder (Soliris only) ☐Paroxysmal nocturnal hemoglobinuria ☐ Other:_____	☐D59.39 ☐G70.00 ☐G36.0 ☐D59.5 ☐ Other:_____	☐ Epysqli/Q5151 ☐ Soliris/J1299 ☐ Bkemv/Q5152	☑ CPT Code: _____

Labs	Notes to Prescriber (prior to initiating therapy)
Prior to scheduling initial infusion: ☑ BMP ☑ CBC ☑ serum LDH Other Labs: ☐ _____ ☐ _____ ☐ _____	- Prescriber and patient must be enrolled in the REMS program - Prescriber to counsel patients on the risk of meningococcal infection; ensure patients are vaccinated and provide educational materials. - Patients should be up to date with all immunizations before initiating therapy - If urgent eculizumab initiation is necessary in a patient that is not up to date with meningococcal vaccines according to current guidelines, provide antibacterial prophylaxis and administer vaccines as soon as possible. - To reduce the risk for meningococcal disease, consider antimicrobial prophylaxis with oral antibiotics (penicillin, or macrolides if penicillin-allergic) for the duration of eculizumab therapy
Follow up labs and frequency: ☐ _____ ☐ _____ ☐ _____	

Nursing Orders	Pre-medications (not required)	
☑ Discharge patient when stable and meets protocol criteria ☑ Decrease infusion rate or discontinue for infusion reactions and notify the provider; do not exceed a maximum 2-hour duration of infusion in adults. ☑ Monitor for at least 1 hour following completion of infusion (for signs/symptoms of infusion reaction)	☐ Acetaminophen 975 mg PO, once ☐ Cetirizine 10 mg PO, once ☐ Dexamethasone 20 mg IV, once ☐ Ondansetron 4 mg IV, once	☐ Diphenhydramine 25 mg PO, once ☐ Diphenhydramine 25 mg IV, once ☐ Other: _____ ☐ Other: _____
Emergency/Anaphylaxis Order		
☑ Follow standard orders for management of allergies and anaphylaxis reactions		

Medication Orders*

	Medication	Route	Dose/Frequency

☐	Eculizumab-aagh (Epysqli)	IV	☐ Induction: 900 mg weekly for 4 doses; Maintenance: 1.2 g at week 5, then 1.2 g every 2 weeks thereafter ☐ Induction: 600 mg weekly for 4 doses; Maintenance: 900 mg at week 5; then 900 mg every 2 weeks thereafter ☐ Supplemental dosing for patients receiving plasmapheresis or plasma exchange (choose one): ☐ 600 mg within 60 minutes after each plasmapheresis or plasma exchange ☐ 300 mg within 60 minutes after each plasmapheresis or plasma exchange ☐ Supplemental dosing for patients receiving fresh frozen plasma infusion: 300 mg within 60 minutes prior to each infusion of fresh frozen plasma ☐ Supplemental dosing for patients receiving concomitant IVIG: **Note: Supplemental eculizumab doses are not required for IVIG <u>acute</u> rescue therapy.** IVIG administered every 4 weeks or more frequently than every 4 weeks: ☐ Most recent eculizumab dose ≥900 mg: Administer an additional eculizumab 600 mg dose at the same time as the regularly scheduled eculizumab dose. ☐ Most recent eculizumab dose ≤600 mg: Administer an additional eculizumab 300 mg dose at the same time as the regularly scheduled eculizumab dose. IVIG administered less frequently than every 4 weeks: ☐ Most recent eculizumab dose ≥900 mg: Administer an additional eculizumab 600 mg dose with the next scheduled eculizumab dose following the last IVIG cycle. ☐ Most recent eculizumab dose ≤600 mg: Administer an additional eculizumab 300 mg dose with the next scheduled eculizumab dose following the last IVIG cycle. ☐ 900 mg weekly for ____ week(s) ☐ Other: _____ **REFILLS:** ☐ Zero / ☐ for 12 months / ☐ Other: _____ **(if not indicated order will expire one year from date signed)**
☐	Eculizumab (Soliris)		
☐	Eculizumab-aeeb (Bkemv)		

* Pharmacy may substitute a biosimilar based on insurance coverage. Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

<u>Infusion Center Staff</u> Please fax infusion records or discharge summary to:	**Fax Number**_____

Provider Signature		**Date**	
Provider Printed Name			