## **Troy Infusion Center**

600 W Main Street Suite 120 Troy, OH 45373 Phone: 937-401-6620 Fax: 937-401-6629



## **Washington Township Infusion Center**

Date:

1989 Miamisburg-Centerville Road Suite 101

Dayton, OH, 45459 Phone: 937-401-6620 Fax: 937-401-6629

## Soliris® (Eculizumab) Order Form Epic Referral: REF115225

Patient Name: DOB:	
Address:	
Phone: ICD-10 Diagnosis:	
Induction (Only check if new to soliris or restarting therapy):	
<ul> <li>□ IV Soliris (eculizumab) 900 mg in 90 mL of 0.9% NaCl infused over 35 minutes weekly x 4 doses followed by maintenance dosing below beginning on week 5</li> <li>• Total preparation volume is 180 mL</li> <li>• Flush with 50 mL of 0.9% NaCl after to ensure entire dose is given</li> </ul>	
Maintenance:	
<ul> <li>□ IV Soliris (eculizumab) 1200 mg in 120 mL of 0.9% NaCl infused over 35 minutes every 2 weeks</li> <li>• Total preparation volume is 240 mL</li> <li>• Flush with 50 mL of 0.9% NaCl after to ensure entire dose is given</li> </ul>	
Order good for:   6 months   1 year   Other duration:	
Other Orders/Comments:	
<u>Vaccines:</u>	
Bexsero or Trumenba (We have Bexsero, however will complete Trumenba series if was started)	
☐ First dose of given on and then complete vaccine series as	3
indicated □ Give Bexsero vaccine series (2 doses ≥ 1 month apart) □ Meningitis group B booster at 1 year from completion of initial series	
Menactra/MenQuadfi (Whatever product is available)	
<ul> <li>□ First dose given on and then give second dose ≥ 2 months after first dose</li> <li>□ Give complete vaccine series (2 doses, 2<sup>nd</sup> dose ≥ 2 months after first dose)</li> </ul>	
**Port/PICC care per protocol will be performed if applicable including heparin flush (500 units/5mL) and cathf (2 ma) PRN for patients with a port**  Prescriber Printed Name:	lo
Prescriber Full Address:	_
Office Phone Number: Office Fax Number:	

Prescriber Signature: