# Eculizumab (Soliris, Bkemv, Epysqli)

***Provider Order Form*** *rev. 11/06/26*

arbor infusion

## PATIENT INFORMATION

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

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐NKDA Allergies:

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

## REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• Is referring provider enrolled in FDA REMS program? ☐Yes ☐No

## DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐G36.0 Neuromyelitis Optica Spectrum Disorder
☐D59.5 Paraxysmal Nocturnal Hemoglobinuria (PNH)
☐D59.39 Other hemolytic-uremic syndrome (aHUS)
☐Other:

## MENINGOCOCCAL VACCINATION

• Has the patient completed the full meningococcal vaccination series?
☐Yes ☐No

• If yes, Fax or attach documentation of administered vaccines

• If no, the patient will receive first dose of Eculizumab at least two weeks after the first dose of the vaccine series. If you want to hold treatment until the patient has completed the full vaccine series, check here ☐

## PRIMARY MEDICATION ORDER

Eculizumab (Soliris) OR eculizumab biosimilar as required by the patient's insurance. Dilute in 0.9% sodium chloride to a final concentration of 5 mg/mL

• Infuse IV over 35 minutes in adults or over 1-4 hours in pediatrics
• Flush with 0.9% sodium chloride at infusion completion
• Patient is required to stay for 60-minute observation post-infusion
• Refill for 12 months unless otherwise noted: _____

☐Generalized Myasthenia Gravis (gMG) -or- Atypical Hemolytic Uremic Syndrome (aHUS) -or- Neuromyelitis Optica Spectrum Disorder (NMOSD)

- ☐***New Start:*** 900 mg IV every week x 4 doses, then 1200mg IV every 2 weeks starting at week 5
- ☐***Maintenance:*** 1200 mg every 2 weeks

☐Paroxysmal Nocturnal Hemoglobinuria (PNH)

- ☐***New Start:*** 600mg IV every week x 4 doses, then 900mg IV every 2 weeks starting at week 5
- ☐***Maintenance:*** 900mg every 2 weeks

☐Other: _____

## PRE-MEDICATION

**Note:** pre-meds not typically indicated for Eculizumab

☐acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO
☐cetirizine (Zyrtec) 10mg PO
☐loratadine (Claritin) 10mg PO
☐famotidine (Pepcid) 20 mg IV
☐diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV
☐methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV
☐Other: _____
Dose: _____ Route: _____

## LABORATORY ORDERS

☐CBC ☐at each dose ☐every _____
☐CMP ☐at each dose ☐every _____
☐Other: _____

## NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

## APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐Opt out (I will manage any denial)

**SPECIAL INSTRUCTIONS**

**Ordering Provider (Print)** **Provider Signature** **Provider NPI** **Date**

☐No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

## PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:
Referring Practice Name: Phone: Fax:
Practice Address: City: State: Zipcode:

## ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐Arbor Infusion Fishers (317) 981-1772
☐Arbor Infusion Carmel (317) 981-1772