INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Eculizumab *Soliris & biosimilars*

☐ Soliris (eculizumab) ☐ Bkemv (eculizumab-aeeb)
☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____
Mobile number _____ Patient weight _____ kg
Allergies _____
☐ Patient has known difficult venous access. Comments: _____
☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00
☐ Myasthenia Gravis with acute exacerbation, ICD 10: G70.01
☐ Neuromyelitis Optica Spectrum Disorder, ICD 10: G36.0
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____
Signature _____ Date _____
Contact name _____ Phone _____ Fax _____
Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Documentation of meningitis vaccine (at least 2 weeks before 1st infusion)
☐ Labs and tests supporting diagnosis
☐ Demographics
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Famotidine 20 mg IV
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE / FREQUENCY	ROUTE
Soliris	☐ Initial: 900 mg weekly x 4 weeks, 1,200 mg week 5, then 1,200 mg every 2 weeks thereafter ☐ Maintenance: 1,200 mg every 2 weeks ☐ Other: _____	IV

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____