



Infusion Center

Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Soliris (Eculizumab) Order Form – J1300

Patient Name: _____	DOB: _____
Diagnosis: _____	Diagnosis Code: _____
Height: _____ (cm) Actual Weight: _____ (kg) Allergies: _____	

***Required prior to treatment initiation: Patient must be immunized with meningococcal vaccines at least 2 weeks prior to administering the first dose of Soliris. If immediate treatment is necessary and patient cannot get vaccinated more than 2 weeks prior to treatment, must provide 2 weeks of antibacterial prophylaxis (penicillin or macrolide based).**

Soliris dosing: IV: 900mg weekly for 4 doses, followed by 1200mg every 2 weeks.

Check all that apply

- Soliris 900mg:** **Weekly x 4 doses**
- Soliris 1200mg:** **Every 2 weeks starting on week 5**
- Other Dose:** **Please specify:** _____

Orders valid through ____ / ____ / ____

Soliris administration: Dose is administered over 35 minutes in normal saline at a concentration of 5mg/ml. Patient will be monitored for 1 hour following completion of infusion.

*** In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____		
Provider Signature: _____	Date: _____	
Phone: _____	Fax: _____	Pager: _____