Local Infusion

MYLOCALINFUSION.COM

ECULIZUMAB (AND BIOSIMILAR) ORDER FORM

❑ Soliris (eculizumab) ❑ Bkemv (eculizumab-aeeb) ❑ Epysqli (eculizumab-aagh)

❑ **Dispense As Written (DAW)**

Will substitute for biosimilar or reference product based on insurance and availability

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 name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Soliris	❑ Initial: 900 mg weekly X 4 weeks, 1200 mg week 5, then 1200 mg every 2 weeks thereafter. ❑ Maintenance: 1200 mg every 2 weeks ❑ Other: _____	IV

LABS / SPECIAL INSTRUCTIONS