BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: ______________________DOB _Date of Last Infusion
Height___________Weight__________

Infusion Location: (state and site) ________________________________

Soliris® (eculizumab) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

☐ G70.00 generalized myasthenia gravis without exacerbation ☐ G36.0 Neuromyelitis optica (NMOSD)

☐ Other: ____________ (ICD-10) ________________________________ (description)

gMG patients:	☐ Patient is anti-acetylcholine receptor antibody positive (provide documentation)
NMOSD patients:	☐ Patient is anti-aquaporin-4 (AQP4) antibody positive (provide documentation)
For all patients:	☐ Meningococcal vaccine(s) given on ____________________(date) First Soliris dose may be given at least 2 weeks later unless otherwise specified

- Nursing: Hold infusion and notify provider for:
  - Signs/symptoms of infection or meningococcal infection such as:
    - Headache with (1) fever, (2) nausea/vomiting, (3) stiff neck/back
    - Muscle aches with flu-like symptoms, fever with or without rash, confusion or photophobia
- Ensure patient carries and understands Patient Safety Information Card

Pre-medications:

☐ Tylenol 500 mg PO ☐ Loratadine 10 mg PO ☐ Solu-Medrol 125 mg IVP ☐ Other:

Dosing: (if infusion is stopped for any reason, total infusion time should not exceed 2 hours)

☐ Administer Soliris 900 mg weekly* x 4 doses.
Dilute with 90 ml 0.9% sodium chloride (final volume 180 ml) and infuse over 35 minutes

☐ Administer Soliris 1200 mg 1 week* later (at week 5), then every 2 weeks* thereafter
Dilute with 120 ml 0.9% sodium chloride (final volume 240 ml) and infuse over 35 minutes

*Recommended dosage time intervals; may adjust +/- 2 days if needed)

Observation Period:

- Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion
- Record vital signs before, during, after and prior to discharge

Additional Orders:

Provider Name (print): ______________________________Date:________________________

Provider Signature: ________________________________Time: _________________________

Reviewed 4/24/23. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.