CIVIC INFUSION

FAX: 203-724-4838

249 Danbury Rd, Wilton, CT 06897

400 Columbus Ave, Valhalla, NY 10595

127 Washington Ave, N. Haven, CT 06473

220 Farmington Ave, Farmington, CT 06032

_____

(eculizumab)

Soliris infusion orders

Patient Name _____ DOB_____

Phone _____ Male Female Other

Weight:_____lbs (_____kg) Height:_____ft _____in

Allergies_____

DIAGNOSIS

Description	Description
Paroxysmal nocturnal hemoglobinuria (PNH)	Neuromyelitis Optica Spectrum disorders (NMOSD)
Atypical hemolytic uremic syndrome (aHUS)	
Myasthenia Gravis (gMG) with AChR antibody positive	_____

ORDERS

Pre-Medication:

Tylenol 1000mg PO | Benedryl 25mg PO | Solu-Medrol 125mg IV

Solu-Cortef 100mg IV Other_____

Adult Dosing:

PNH (Inifial Dose): 600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mb IV every 2 weeks thereafter

Maintenance Dose: 900mg IV every 2 weeks

aHUS, gMG, and NMOSD (Initial Dose): 900mb IV weekly for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter

Maintenance Dose: 1200mg IV every 2 weeks

Prescriber must indicate the following requirements have been met (please provide documentation):

Meningococcal vaccine at least 2 weeks prior to starting treatment

Positive serologic test (if NMOSD or Myasthenia Gravis diagnosis)

CBC within 1 year

NOTES

ORDERING PROVIDER

Signature_____Date_____

Provider_____Phone_____FAX_____