Eculizumab (Soliris, BKEMV, Epysqli)

Provider Order Form rev. 06/23/2026

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Atypical Hemolytic Uremic Syndrome (aHUS): Neuromyelitis Optica (NMOSD):

Paroxymanl Nocturnal Hemoglobinuria (PNH): generalized Myasthenia Gravis (gMG):

Other: Description:

REQUIRED INFORMATION

Men ACWY: Date of 1st dose: _____ Brand: _____
Date of 2nd dose: _____ Brand: _____
Men B: Date of 1st dose: _____ Brand: _____
Date of 2nd dose: _____ Brand: _____
(Trumenba only) Date of 3rd dose: _____
Prophylactic antibiotics prescribed: ☐ Yes / ☐ No
Date patient started prophylactic antibiotics *(if applicable)*: _____
Provider REMS ID: _____

☐ **For gMG diagnosis**: Patient is anti-acetylcholine receptor antibody positive
☐ **For NMSOD diagnosis:** Patient is anti-aquaporin-4 (AQP4) antibody positive

THERAPY ADMINISTRATION & DOSING *(Choose one)*

☐ Administer Eculizumab or Eculizumab biosimilar.
☐ Administer this specific Eculizumab product: _____

aHUS, gMG, and NMOSD Diagnosis

☐ Administer 900mg weekly[1] x4 doses. Then administer 1200mg for the fifth dose one week after the fourth dose (week 5), then every 2 weeks[1] thereafter.
☐ Maintenance only: Administer 1200mg every 2 weeks[1].

PNH Diagnosis

☐ Administer 600mg weekly[1] x4 doses. Then administer 900mg for the fifth dose one week after the fourth dose (week 5), then every 2 weeks[1] thereafter.
☐ Maintenance only: Administer 900mg every 2 weeks[1].
[1]Recommended dosage time intervals; may adjust +/- 2 days if needed

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

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.
☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation.
☑ If infusion is stopped for any reason, total infusion time should not exceed 2 hours
☑ Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Disease status, MRI, Flow Cytometry, MG classification, MG-ADL score, EMG results
Required Labs: Anti-Ach receptor and/or Anti-AQP4

Provider Name *(print)* **Provider Signature** **Date**

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.