Clearwell Infusion Centers

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SOLIRIS (Eculizumab)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

Meningococcal Vaccination Status:

- ☐ Primary vaccination series completed - date: _____
- ☐ MenACWY booster completed - date: _____
- ☐ MenB booster completed - date: _____

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

- ☐ Acetaminophen 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Ceterizine 10mg PO
- ☐ Loratadine 10mg PO
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ Other:

PRIMARY MEDICATION ORDER

Dosage and Frequency

☐ Loading dose:
- ☐ 600 mg IV weekly x 4 weeks
- ☐ 900 mg IV weekly x 4 weeks
- ☐ Other: _____

☐ Maintenance dose:
- ☐ 900 mg IV on week 5, then every 2 weeks thereafter
- ☐ 1200 mg IV on week 5, then every 2 weeks thereafter
- ☐ _____ mg IV every 2 weeks
- ☐ Other: _____

Patient Weight:

_____ lbs
_____ kg

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____
Practice Address: _____
City, State, Zip: _____

Provider Signature: _____ Date: _____