KAISER PERMANENTE®

**Kaiser Permanente Washington Home Infusion Pharmacy (KPWAHIP)**
**Soliris (Eculizumab) Prescription Referral Form**
Phone: (206) 326-2990 **Fax Referral To: (206) 326-2139**

## 1 PATIENT INFORMATION

**Patient Name:** _____
**Phone:** _____
**Address:** _____
**City:**_____**State:**_____**Zip:**_____
**MRN #:** _____
**DOB:** _____
**Drug Allergies:** _____

## 2 PRESCRIBER INFORMATION

**Prescriber's Name:** _____
**DEA#:** _____**NPI:** _____
**Clinic/Facility Name:** _____
**Address:** _____
**City:** _____**State:** _____**ZIP:** _____
**Phone:** _____**Fax:** _____

## 3 Instructions to Provider

All orders with ✓ will be placed unless otherwise noted. Please fax completed order form to 206-326-2139. For drug prior authorization, call 1-888-767-4670 or visit https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice. Prescribers must be specially certified in the *Soliris* REMS program and comply with instructions for use.

## 4 CLINICAL INFORMATION

**Diagnosis (ICD-10 code)**: _____ **Date of Last Dose:** _____

## 5 SOLIRIS PRESCRIPTION INFORMATION

**Eculizumab (Soliris) in 0.9% Sodium Chloride Injection, USP, dilute to a final concentration of 5 mg/mL**
**First Dose:** □ No □ Yes **Weight:** _____kg **Date Recorded:** _____
**Dose**: □ **900 mg** □ **1200 mg** □ **Other**_____ **mg** Route: Intravenous
**Frequency:** □ **Every 2 weeks** □ **Other**_____ **(wk)**
**Refills:** □ 11 months □ Other _____
**Infusion Access:** □ PIV □ CVAD □ Other: _____
**Patient's Current Home Care/Specialty Pharmacy:** _____

**Infusion Reaction Medications & Supplies**

- ✓ **Hydrocortisone sodium succinate injectable 100 mg IV**
  **Sig:** Once PRN for hypersensitivity
- ✓ **Epinephrine Auto-Injector** □ 0.15mg □ 0.3mg **QTY**: 2
  **Sig:** Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use.
- ✓ **Diphenhydramine injectable 25 mg IV**
  **Sig:** Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath
- ✓ **Sodium Chloride 0.9% IV 250ml Bag**
  **Sig:** Once PRN for anaphylaxis

✓ **Sodium Chloride 0.9% IV Flush**: Flush 10 ml IV before/after medication administration or as needed for line maintenance

**Labs /Special Instructions/Pre-Meds:** _____
_____
_____

**Infusion Protocol:**

- Infuse per manufacturer guidelines
- Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4; then every 30 minutes x2; then every 60 minutes until completion of infusion
- Documentation must include:
  - Start and end time of infusion
  - All rate changes, vital signs, including initial and final set
  - Patient response
- Observe patient for signs of infusion rate-related adverse reactions:
  - Blood pressure changes, increased pulse rate
  - Fever, chills
  - Headache
  - Chest, back or hip pain
  - Dyspnea
  - Mild erythema

## 6 PHYSICIAN SIGNATURE REQUIRED

| X | | X | |
|---|---|---|---|
| *SUBSTITUTION PERMITTED* | *(Date)* | DISPENSE AS WRITTEN | (Date) |


**Members with Medicare Part B or D coverage are not required to use this form.**