Novella Infusion

Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

# Eculizumab (Soliris®) Infusion Orders

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

_____ Generalized myasthenia gravis (gMG) (ICD-10)

_____ Neuromyelitis optica spectrum disorder (NMOSD) (ICD-10)

_____ Other: _____ (ICD-10)

| | |
|---|---|
| **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)<br>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, planned/recent surgical procedures
- Signs/symptoms of meningococcal infection such as:
  - Headache accompanied by either (1) fever, (2) nausea/vomiting, (3) stiff neck/back
  - Fever with or without rash
  - Muscle aches with flu-like symptoms
  - Confusion
  - Photophobia

☑ Ensure patient carries and understands Patient Safety Information Card
☑ Monitor vital signs before and after infusion.
☑ If infusion-related reaction occurs, stop infusion and initiate Hypersensitivity Reaction Management Protocol as clinically indicated.

**Pre-medications**:

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

☑ **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 prior to discharge.

Provider: _____

Provider signature: _____ Date: _____

Revised 10/1/19. 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.