Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

SOLIRIS MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____

■ **Diagnosis** *Some insurance carriers require both diagnosis codes below for prior authorization.*

☐ G70.00 Myasthenia gravis without (acute) exacerbation ☐ G70.01 Myasthenia gravis with (acute) exacerbation

■ **Details Needed for Authorization** *Please answer all questions and provide supporting documentation.*

For paroxysmal nocturnal hemoglobinuria (PNH):

- If the patient has PNH, provide results of PNH clone detection by flow cytometry, and baseline values of one or more of the following tests: Serum LDH, hemoglobin level, and packed RBC transfusion requirements.
- Circle the appropriate indication(s) for this patient's therapy: a) thrombotic event b) organ damage secondary to chronic hemolysis c) patient is pregnant and potential benefit outweighs potential fetal risk d) patient is transfusion dependent e) patient has high LDH with clinical symptoms
- Does the patient have failure on or contraindication to Ultomiris (ravulizumab)? _____

For atypical hemolytic uremic syndrome (aHUS):

- Have you ruled out STEC-HUS, typical HUS, and infection related HUS? _____
- Have you ruled out coexisting diseases or conditions, S. pneumonia, Influenza A H1N1 or cobalamin deficiency? _____
- Have you ruled out thrombocytopenic purpura (TTP)? _____
- Provide baseline values of the following: LDH, serum creatinine/eGFR, platelet count, and plasma exchange/infusion requirement.
- Does the patient have failure on or contraindication to Ultomiris (ravulizumab)? _____

For AchR AB+ generalized myasthenia gravis (gMG):

- Does the patient have MGFA Clinical Classification of Class II to Class IV? _____ If yes, what is the Classification? _____
- Provide assessment of the baseline Quantitative Myasthenia Gravis (QMG) score.
- Does the patient have an MG-ADL total score of ≥6? _____ If yes, what is the score? _____
- Has the patient failed treatment over at least 1 year with at least 2 immunosuppressive therapies, or has failed at least 1 immunosuppressive therapy and required chronic plasmapheresis or plasma exchange (PE) or intravenous immunoglobulin (IVIG)? _____

For AQP4 AB+ NMOSD:

- Does the patient have a history of ≥2 relapses in last 12 months, or 3 relapses in the last 24 months, with at least 1 in the past year? _____
- Is the patient's EDSS score ≤7? _____ If yes, what is the score? _____
- If the patient is on immunosuppressive therapy, is the dose stable? _____ If yes, what is the daily medication and dose? _____
- Was the patient treated with rituximab or mitoxantrone within 3 months, or IVIg within 3 weeks? _____
- Has the patient had failure on or contraindication to rituximab (Rituxan) or inebilzumab (Uplizna)? _____
- Will the patient be on Soliris concurrently with rituximab, inebilizumab or satralizumab? _____

■ **Soliris (eculizumab) Medication Order** **Patient's height in ft/in: _____ Patient's weight in lbs: _____**

☐ Initial treatment phase, 900mg weekly for 4 weeks

☐ Subsequent treatment cycle, 1200mg every other week, starting 1 week after the last Initial treatment phase therapy, for 1 year.

The final concentration of Soliris after dilution is 5 mg/ml, with each 300mg 30ml vial of Soliris being diluted in another 30ml of normal saline or D5; a 900mg dose's final volume is 180ml, a 1200mg dose's final volume is 240ml. Administer over 35 minutes in adults. Follow manufacturer's instructions.

■ **Rescue Management in case of Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ **Ordering Provider Authorization**

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone Line to Contact Person: _____

STANDARD DOCUMENTATION TO INCLUDE:

Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides). Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results. If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.