

Princeton / Somerset New Jersey  
49 Veronica Avenue  
Suite 202  
Somerset, NJ 08873

Long Branch  
422 Morris Avenue  
Suite 7  
Long branch, NJ 07740

Marlton  
127 Church Road  
Suite 600  
Marlton, NJ 08053



# INFUSION ORDERS SOLIRIS (ECULIZUMAB)

Date: \_\_\_\_\_

## PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

## REFERRAL STATUS

<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> Discontinuation
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## INFUSION OFFICE PREFERENCES (Optional)

Preferred Location\*:

\*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

## DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> Atypical Hemolytic Uremic Syndrome (aHUS)	ICD 10 Code: D59.3	<input type="checkbox"/> Other _____
<input type="checkbox"/> Myasthenia Gravis, Acetylcholine Receptor Antibody Positive	ICD 10 Code: G70.00	
<input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5	
<input type="checkbox"/> Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code: G36.0	

## REQUIRED DOCUMENTATION

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis)	<input type="checkbox"/> Aquaporin 4 Antibody Test Results (if NMO)
	<input type="checkbox"/> Documentation of meningococcal vaccines

Is your patient enrolled in the Soliris-REMS program?  YES  NO

List tried & failed therapies (if Myasthenia Gravis):

1) \_\_\_\_\_

2) \_\_\_\_\_

## MEDICATION ORDERS

Dosing for aHUS, Myasthenia Gravis, and NMO	<input type="checkbox"/> Soliris 900mg IV once weekly for 4 weeks, followed by 1200mg IV at week 5, then 1200mg IV every 2 weeks thereafter <input type="checkbox"/> Soliris _____ mg IV every _____ <input type="checkbox"/> Other _____
Dosing for PNH	<input type="checkbox"/> Soliris 600mg IV once weekly for 4 weeks, followed by 900mg IV at week 5, then 900mg IV every 2 weeks thereafter <input type="checkbox"/> Soliris _____ mg IV every _____ <input type="checkbox"/> Other _____

Refills:  X 6 months  X 1 year  \_\_\_\_\_ doses

## PRESCRIBER INFORMATION

Prescriber Name :	Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:		

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_