

INFUSION ORDERS SOLIRIS (ECULIZUMAB)

Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

New Referral
 Dose or Frequency Change
 Order Renewal
 Discontinuation

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, Aceptylcholine 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"/> Patient demographics AND insurance information <input type="checkbox"/> Acetyl choline Receptor Antibody Test Results (if Myasthenia Gravis)	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Aquaporin 4 Antibody Test Results (if NMO) <input type="checkbox"/> Documentation of meningococcal vaccines
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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 _____