Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

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

☐ Atypical Hemolytic Uremic Syndrome (aHUS)	ICD 10 Code: D59.3	☐ Other_____
☐ Myasthenia Gravis, Aceytlcholine Receptor Antibody Positive	ICD 10 Code: G70.00	
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5	
☐ Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code:G36.0	

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Acetylc holine Receptor Antibody Test Results (if Myasthenia Gravis)	☐ Aquaporin 4 Antibody Test Results (if NMO)
	☐ 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	☐ Soliris 900mg IV once weekly for 4 weeks, followed by 1200mg IV at week 5, then 1200mg IV every 2 weeks thereafter ☐ Soliris _____ mg IV every _____ ☐ Other_____
Dosing for PNH	☐ Soliris 600mg IV once weekly for 4 weeks, followed by 900mg IV at week 5, then 900mg IV every 2 weeks thereafter ☐ Soliris _____ mg IV every _____ ☐ 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 _____