Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830

Office: 212-803-3339 Fax : 646-768-8600

INFUSION ORDERS
SOLIRIS (ECULIZUMAB)

Date: ____________________

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS			
☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal	☐ Discontinuation

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 ____________________