

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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, Acetylcholine 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 |
| ☐ Acetylcholine 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 _____