

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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

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"/> Patient demographics AND insurance information <input type="checkbox"/> Acetylcholine 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
Is your patient enrolled in the Soliris-REMS program? <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses	

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

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____