SOLIRIS
(eculizumab)

FAX to +1 208.963.3245 or Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

• Is referring provider enrolled in FDA REMS program? ☐ Y ☐ N
• Has the patient received the Meningitis vaccination? ☐ Y ☐ N Date of completion:_____

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)
☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Soliris
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Generalized Myasthenia Gravis (gMG) – or – Atypical Hemolytic Uremic Syndrome (aHUS)
☐ Soliris 900mg IV every week x 4 doses, then 1200mg IV every 2 weeks starting at week 5
☐ Soliris_____mg IV every_____weeks

Paroxysmal Nocturnal Hemoglobinuria (PNH)
☐ Soliris 600mg IV every week x 4 doses, then 900mg IV every 2 weeks starting at week 5
☐ Soliris_____mg IV every_____weeks

☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialists.org com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialists.org com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____