MIC | METRO INFUSION CENTER

# INFUSION ORDERS- SOLIRIS (ECULIZUMAB)

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

| REFERRAL STATUS |
|---|
| ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal |

| 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 |
| ☐ 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<br>☐ Patient demographics AND insurance information<br>☐ Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis) | ☐ Clinical/Progress notes supporting primary diagnosis<br>☐ Labs and Tests supporting primary diagnosis<br>☐ Aquaporin 4 Antibody Test Results (if NMO)<br>☐ Documentation of meningococcal vaccines |
| Is your patient enrolled in the Soliris-REMS program? ☐ YES ☐ NO | |
| List tried & failed therapies (if Myasthenia Gravis):<br>1)<br>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<br>☐ Soliris _____ mg IV every _____ |
| 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<br>☐ Soliris _____ mg IV every _____ |
| Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses | |

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

**Fax referral to (866) 507-1164 or email to MICreferral@metroinfusioncenter.com**

All information contained in this form is strictly confidential and will become part of the patient's medical record.

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