eculizumab (Soliris)

MIC | METRO INFUSION CENTER

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

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date:			Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

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/Testing	
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx ☐ 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 ☐ N

Is the ordering **PROVIDER** enrolled in the Soliris-REMS program? ☐ YES ☐ N (if no, must be enrolled to start therapy)

List Tried & Failed Therapies (if Myasthenia Gravis)

1) 2)

VACCINATION DATE(s)		
MenACWY	**MenB**	**MenABCWY**
1st Dose Date: ____ /____ /____ ☐ Menveo ☐ Menactra ☐ MenQuadfi 2nd Dose Date: ____ /____ /____ ☐ Menveo ☐ Menactra ☐ MenQuadfi	1st Dose Date: ____ /____ /____ ☐ Bexsero ☐ Trumenba 2nd Dose Date: ____ /____ /____ ☐ Bexsero ☐ Trumenba	1st Dose Date: ____ /____ /____ ☐ Penbraya 2nd Dose Date: ____ /____ /____ ☐ Penbraya

Complete or update vaccination for meningococcal bacteria (for serogroups A, C, W, Y, and B) at least 2 weeks prior to the first dose of SOLIRIS, unless the risks of delaying SOLIRIS therapy outweigh the risk of developing a serious infection. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against meningococcal bacteria in patients receiving a complement inhibitor.

MEDICATION ORDER	
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 1200mg IV every 2 weeks ☑ Soliris _____ mg IV every _____weeks

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

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

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 900 mg IV every 2 weeks ☐ Soliris _____ mg IV every _____weeks
Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____ **(if not indicated order will expire one year from date signed)*	

Provider Name (Print) **Physician Signature:** **Date:**

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