☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Office: 212-803-3339 Fax : 646-768-8600

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

INFUSION ORDERS
SOLIRIS (ECULIZUMAB)

Date: ________________

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

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

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

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	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Acetylc holine 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 ______________
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 ______________
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 _____________