

Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076



INFUSION ORDERS SOLIRIS (ECULIZUMAB)

Date: _____

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal	☐ Discontinuation
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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	☐ Other _____
☐ Myasthenia Gravis, Acetylcholine 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
☐ 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	☐ NO
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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 _____ ☐ Other _____
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 _____ ☐ Other _____
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 _____