

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

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

- | | | |
|--|---------------------|--------------------------------------|
| <input type="checkbox"/> Atypical Hemolytic Uremic Syndrome (aHUS) | ICD 10 Code: D59.3 | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Myasthenia Gravis, Acetylcholine Receptor Antibody Positive | ICD 10 Code: G70.00 | |
| <input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria (PNH) | ICD 10 Code: D59.5 | |
| <input type="checkbox"/> Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive | ICD 10 Code:G36.0 | |

REQUIRED DOCUMENTATION

- | | |
|--|---|
| <input type="checkbox"/> This signed order form by the provider | <input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis |
| <input type="checkbox"/> Patient demographics AND insurance information | <input type="checkbox"/> Labs and Tests supporting primary diagnosis |
| <input type="checkbox"/> Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis) | <input type="checkbox"/> Aquaporin 4 Antibody Test Results (if NMO) |
| | <input type="checkbox"/> 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	<input type="checkbox"/> Soliris 900mg IV once weekly for 4 weeks, followed by 1200mg IV at week 5, then 1200mg IV every 2 weeks thereafter <input type="checkbox"/> Soliris _____ mg IV every _____ <input type="checkbox"/> Other _____
---	--

Dosing for PNH	<input type="checkbox"/> Soliris 600mg IV once weekly for 4 weeks, followed by 900mg IV at week 5, then 900mg IV every 2 weeks thereafter <input type="checkbox"/> Soliris _____ mg IV every _____ <input type="checkbox"/> 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 _____