# Soliris® Order Form

amerita specialty infusion services

Eventus Infusion an amerita company

**Fax Completed Form To:** **Phone:**

## PATIENT INFORMATION

| | | |
|---|---|---|
| Patient Name: | Date of Birth: | Referral Date: |
| Address: | | City/State/Zip: |
| Home Phone: | Cell Phone: | Work Phone: |
| Secondary Contact: | Height: Weight: | ☐ Male ☐ Female |
| Patient Diagnosis & ICD-10: | | |
| Allergies: | | |

## PROVIDER INFORMATION

| | | |
|---|---|---|
| Physician Name: | Lic.#: | DEA #: |
| Practice Name: | | NPI#: |
| Address: | | City/State/Zip: |
| Office Contact: | Phone: | Fax: |
| Supervisory Physician (if applicable): | | |

## PLEASE ATTACH

- ☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
- ☐ Recent office visit notes, history & physical, lab & pertinent procedure results
- ☐ Current medication list & list of prior medications tried and failed (with dates)
- ☐ Line access documentation/verification if applicable
- ☐ Vaccine status (any vaccination) and documentation of any recent vaccinations
- ☐ Clinical documentation on any recent meningococcal infections
- ☐ Documentation of a meningococcal vaccination
- ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

## NURSING & LAB ORDERS

**Nurse Orders:** Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.
**Flush Orders:** *NaCl 0.9%* - 5-10mL flush pre and post infusion and as needed *Heparin* - ☐ 10units/mL ***---OR---*** ☐100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line
**Lab Orders:** **Lab Date & Frequency:**

## PRESCRIPTION ORDERS

**Anaphylaxis Kit:** (Check all that apply)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other

**Pre-Medications:** (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV infusion _____minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV infusion _____minutes prior to infusion ☐ Other

**Supply Orders:** All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

| PRODUCT | PRESCRIPTION INFORMATION | REFILLS |
|---|---|---|
| | Is this a first dose? ☐ Yes ☐ No If No, when was last dose given?_____ When is patient due for next dose?_____ | |
| | Is the prescriber enrolled in the Soliris REMS program? ☐ Yes ☐ No | |
| ☐ Soliris Induction (≥18 years of age) | ☐ **PNH** ☐ 600 mg IV infusion via ☐ gravity ***---OR---*** ☐ pump every 7 days for 4 weeks over 35 minutes<br>☐ **aHUS, gMG and NMOSD** ☐ 900 mg IV infusion via ☐ gravity ***---OR---*** ☐ pump every 7 days for 4 weeks over 35 minutes | NONE |
| ☐ Soliris Maintenance (≥18 years of age) | ☐ **PNH** ☐ 900 mg IV infusion via ☐ gravity or ☐ pump every 2 weeks starting week 5 over 35 minutes<br>☐ **aHUS, gMG and NMOSD** ☐ 1,200 mg IV infusion via ☐ gravity or ☐ pump every 2 weeks starting week 5 over 35 minutes | _____ |
| ☐ Soliris Induction (<18 years of age ) | **aHUS** ☐ For patients 5-10kg administer 300mg IV infusion via ☐ gravity ***---OR---*** ☐ pump once weekly X 1 dose over 1 to 4 hours<br>☐ For patients 10-20kg administer 600mg IV infusion via ☐ gravity ***---OR---*** ☐ pump once weekly X 1 dose over 1 to 4 hours<br>☐ For patients 20-30kg administer 600mg IV infusion via ☐ gravity ***---OR---*** ☐ pump once weekly X 2 doses over 1 to 4 hours<br>☐ For patients 30-40kg administer 600mg IV infusion via ☐ gravity ***---OR---*** ☐ pump once weekly X 2 doses over 1 to 4 hours<br>☐ For patients >40kg administer 900 mg IV infusion via ☐ gravity ***---OR---*** ☐ pump once weekly X 4 doses over 1 to 4 hours | NONE |
| ☐ Soliris Maintenance (<18 years of age ) | **aHUS** ☐ For patients 5-10kg administer 300 mg IV infusion via ☐ gravity ***---OR---*** ☐ pump starting at week 2 then 300mg every 3 weeks over 1 to 4 hours<br>☐ For patients 10-20kg administer 300 mg IV infusion via ☐ gravity ***---OR---*** ☐ pump starting at week 2 then 300mg every 2 weeks over 1 to 4 hours<br>☐ For patients 20-30kg administer 600 mg IV infusion via ☐ gravity ***---OR---*** ☐ pump starting at week 3 then 600mg every 2 weeks over 1 to 4 hours<br>☐ For patients 30-40kg administer 900mg IV infusion via ☐ gravity ***---OR---*** ☐ pump starting at week 3 then 900mg every 2 weeks over 1 to 4 hours<br>☐ For patients >40kg administer 1,200mg IV infusion via ☐ gravity ***---OR---*** ☐ pump starting at week 5 then 1,200mg every 2 weeks over 1 to 4 hours | _____ |
| ☐ OTHER | | _____ |

***By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.***

**Prescriber's Signature** **Print Name** **Date**
**Dispense as Written**

**Prescriber's Signature** **Print Name** **Date**
**Substitution Permitted**