Soliris® Order Form

Fax Completed Form To: **Phone:**

amerita specialty infusion services   **NEXTRON** Infusion Services an amerita company

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

Pre-Medications:	Acetaminophen _____mg PO _____ minutes prior to infusion	Solu-Medrol _____mg IV infusion _____minutes prior to infusion
(Check all that apply)	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 **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 **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 For patients 10-20kg administer 600mg IV infusion via gravity ---*OR*--- pump once weekly X 1 dose over 1 to 4 hours For patients 20-30kg administer 600mg IV infusion via gravity ---*OR*--- pump once weekly X 2 doses over 1 to 4 hours For patients 30-40kg administer 600mg IV infusion via gravity ---*OR*--- pump once weekly X 2 doses over 1 to 4 hours 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 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 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 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 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

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ACHC ACCREDITED   PCAB ACCREDITED Compounding Pharmacy