

Soliris® Order Form



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:	<input type="checkbox"/> Male <input type="checkbox"/> 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		
<input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical) <input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results <input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates) <input type="checkbox"/> Line access documentation/verification if applicable <input type="checkbox"/> Vaccine status (any vaccination) and documentation of any recent vaccinations <input type="checkbox"/> Clinical documentation on any recent meningococcal infections <input type="checkbox"/> Documentation of a meningococcal vaccination <input type="checkbox"/> 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 - <input type="checkbox"/> 10units/mL ---OR--- <input type="checkbox"/> 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders:		
Lab Date & Frequency:		
PRESCRIPTION ORDERS		
Anaphylaxis Kit: <input type="checkbox"/> Epinephrine 0.3mg IM as needed <input type="checkbox"/> Solu-cortef 250mg-500mg IV infusion as needed <input type="checkbox"/> Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) <input type="checkbox"/> Diphenhydramine _____ mg IV infusion as needed <input type="checkbox"/> NS Hydration 500 ml IV infusion over 30 minutes as needed <input type="checkbox"/> Other		
Pre-Medications: <input type="checkbox"/> Acetaminophen _____ mg PO _____ minutes prior to infusion <input type="checkbox"/> Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion (Check all that apply) <input type="checkbox"/> Diphenhydramine _____ mg <input type="checkbox"/> PO ---OR--- <input type="checkbox"/> IV infusion _____ minutes prior to infusion <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, when was last dose given? _____ When is patient due for next dose? _____		
Is the prescriber enrolled in the Soliris REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Soliris Induction (≥18 years of age)	<input type="checkbox"/> PNH <input type="checkbox"/> 600 mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump every 7 days for 4 weeks over 35 minutes <input type="checkbox"/> aHUS, gMG and NMOSD <input type="checkbox"/> 900 mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump every 7 days for 4 weeks over 35 minutes	NONE
<input type="checkbox"/> Soliris Maintenance (≥18 years of age)	<input type="checkbox"/> PNH <input type="checkbox"/> 900 mg IV infusion via <input type="checkbox"/> gravity or <input type="checkbox"/> pump every 2 weeks starting week 5 over 35 minutes <input type="checkbox"/> aHUS, gMG and NMOSD <input type="checkbox"/> 1,200 mg IV infusion via <input type="checkbox"/> gravity or <input type="checkbox"/> pump every 2 weeks starting week 5 over 35 minutes	_____
<input type="checkbox"/> Soliris Induction (<18 years of age)	aHUS <input type="checkbox"/> For patients 5-10kg administer 300mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump once weekly X 1 dose over 1 to 4 hours <input type="checkbox"/> For patients 10-20kg administer 600mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump once weekly X 1 dose over 1 to 4 hours <input type="checkbox"/> For patients 20-30kg administer 600mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump once weekly X 2 doses over 1 to 4 hours <input type="checkbox"/> For patients 30-40kg administer 600mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump once weekly X 2 doses over 1 to 4 hours <input type="checkbox"/> For patients >40kg administer 900 mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump once weekly X 4 doses over 1 to 4 hours	NONE
<input type="checkbox"/> Soliris Maintenance (<18 years of age)	aHUS <input type="checkbox"/> For patients 5-10kg administer 300 mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump starting at week 2 then 300mg every 3 weeks over 1 to 4 hours <input type="checkbox"/> For patients 10-20kg administer 300 mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump starting at week 2 then 300mg every 2 weeks over 1 to 4 hours <input type="checkbox"/> For patients 20-30kg administer 600 mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump starting at week 3 then 600mg every 2 weeks over 1 to 4 hours <input type="checkbox"/> For patients 30-40kg administer 900mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump starting at week 3 then 900mg every 2 weeks over 1 to 4 hours <input type="checkbox"/> For patients >40kg administer 1,200mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump starting at week 5 then 1,200mg every 2 weeks over 1 to 4 hours	_____
<input type="checkbox"/> OTHER		_____
<i>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.</i>		
Prescriber's Signature Dispense as Written	Print Name	Date
Prescriber's Signature Substitution Permitted	Print Name	Date