

# Soliris® Order Form

Fax Completed Form To:

Phone:

**Amerita**  
YOUR INFUSION ADVOCATE

| 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)<br><input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results<br><input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates)<br><input type="checkbox"/> Line access documentation/verification if applicable                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                       |
| <input type="checkbox"/> Vaccine status (any vaccination) and documentation of any recent vaccinations<br><input type="checkbox"/> Clinical documentation on any recent meningococcal infections<br><input type="checkbox"/> Documentation of a meningococcal vaccination<br><input type="checkbox"/> Letter of medical necessity if drug dosing or indication is outside of FDA guidelines                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                       |
| NURSING & LAB ORDERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                       |
| <b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.<br><b>Flush Orders:</b> 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<br><b>Lab Orders:</b> <b>Lab Date &amp; Frequency:</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                       |
| PRESCRIPTION ORDERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                       |
| <b>Anaphylaxis Kit:</b> <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<br>(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                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                       |
| <b>Pre-Medications:</b> <input type="checkbox"/> Acetaminophen _____ mg PO _____ minutes prior to infusion <input type="checkbox"/> Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion<br>(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                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                       |
| <b>Supply Orders:</b> 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 REMS program? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                       |
| <input type="checkbox"/> Soliris Induction<br>(≥18 years of age)<br><input type="checkbox"/> BKEMVI (not for NMOSD)<br><input type="checkbox"/> Epysqli (not for NMOSD)                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> <b>PNH</b> <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<br><input type="checkbox"/> <b>aHUS, gMG and NMOSD</b> <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<br>(≥18 years of age)<br><input type="checkbox"/> BKEMVI (not for NMOSD)<br><input type="checkbox"/> Epysqli (not for NMOSD)                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> <b>PNH</b> <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<br><input type="checkbox"/> <b>aHUS, gMG and NMOSD</b> <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<br>(<18 years of age)                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>aHUS</b> <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<br><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<br><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<br><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<br><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<br>(<18 years of age)                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>aHUS</b> <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<br><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<br><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<br><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<br><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                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | _____                                                                 |

*By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.*

Prescriber's Signature  
Dispense as Written

Print Name

Date

Prescriber's Signature  
Substitution Permitted

Print Name

Date