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:	☐ 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 REMS program? ☐ Yes ☐ No	
☐ Soliris Induction (≥18 years of age) ☐ BKEMVI (not for NMOSD) ☐ Epysqli (not for NMOSD)	☐ **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) ☐ BKEMVI (not for NMOSD) ☐ Epysqli (not for NMOSD)	☐ **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 to assist with prior authorization requests acting as your pharmacy provider 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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THIS FORM IS NOT VALID FOR USE IN THE STATE OF ARIZONA.

ACHC ACCREDITED PCAB ACCREDITED Compounding Pharmacy