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:	☐ 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		_____

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

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