

Soliris Order Form



Fax completed form to: _____

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 Diphenhydramine _____ mg IV infusion as needed	Solu-cortef 250mg-500mg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed	Solu-Medrol 60mg - 125mg IV infusion as needed Other
Pre-Medications: (Check all that apply)	Acetaminophen _____ mg PO _____ minutes prior to infusion Diphenhydramine _____ mg PO ---OR--- IV infusion _____ minutes prior to infusion	Solu-Medrol _____ mg 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 _____
Dispense as Written

Print Name

Date

Prescriber's Signature _____
Substitution Permitted

Print Name

Date