Soliris

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Address: City: State: Zip Code:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

☐ Patient has received both of the required meningitis vaccines (MenACWY and MenB). Date(s) of vaccinations: _____

Note: All patients are required to receive meningitis vaccinations at least 2 weeks prior to initiating Soliris unless initiation of Soliris is urgent. Please supply the vaccination records.

ICD-10 CODE

☐ D59.5 Paroxysmal nocturnal hemoglobinuria (PNH) ☐ D58.9 Hereditary hemolytic anemia, unspecified ☐ G70.00 Myasthenia Gravis

☐ G36.0 Neuromyelitis optica spectrum disorder (NMOSD) ☐ Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO **Diphenhydramine** (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Cetirizine (Zyrtec) ☐ 10mg PO **Methylprednisolone** (Solu-Medrol) ☐ 40mg IV ☐ 125mg IV

Loratadine (Claritin) ☐ 10mg PO **Hydrocortisone** (Solu-Cortef) ☐ 100mg IV

Other: _____ Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Soliris (eculizumab)

Initiation therapy:

☐ 600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mgIV every 2 weeks thereafter

☐ 900mg IV weekly for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter

☐ Other: _____

Maintenance therapy:

☐ 900mg IV every 2 weeks

☐ 1200mg IV every 2 weeks

☐ Other: _____

Meningococcal vaccination

☐ AleraCare will administer a Meningococcal Conjugate (MenACWY) Vaccine and a Serogroup B Meningococcal (MenB) Vaccine series.
If not checked, then please submit documentation with meningococcal vaccination information.

☐ Urgent administration is needed and antibiotic prophylaxis was prescribed.

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ☐ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.