ADDRESS: 12144 DAIRY ASHFORD RD. SUITE 100 SUGAR LAND, TX 77478

DELIVERIT
Infusion & Specialty

PHONE: (832) 939-8137
FAX: (832) 939-8128

SOLIRIS (ECULIZUMAB) INFUSION ORDERS

☐ **Infused at MDO.**

☐ **Infused at Home.** SET UP OF SKILLED NURSING VISITS REQUIRED.

COMPLETE PATIENT DEMOGRAPHIC INFORMATION IN SECTION BELOW

Or Attach Face Sheet from Patient Chart

Patient Name:		DOB:	Gender: ☐Male ☐Female	Weight:	☐lbs ☐kg
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip code :	

COMPLETE PATIENT INSURANCE INFORMATION IN THE SECTION BELOW

Or Attach Copies of Patient's Insurance Card

Primary insurance Carrier:	Name of the Insured:	Relationship:
Member ID #:	Group #:	Insurance Phone #:
Secondary Rx Carrier Name:	Rx ID #:	Rx Group #:

MEDICAL INFORMATION

(Check any that apply)

Diagnosis:
- ☐ Paroxysmal nocturnal hemoglobulinuria (PNH) ICD-10 Code: _____
- ☐ Atypical hemolytic syndrome (aHUS) ICD-10 Code: _____
- ☐ Myasthenia Gravis (gMG) with AchR antibody positive ICD-10 Code: _____

Allergies:

☐ Clinical / Progress Notes, Labs, Tests supporting primary diagnosis and including past tried and/or failed therapies, intolerance, outcomes or contradictions to conventional therapy

☐ Positive serologic test for anti-AchR antibodies (if Myasthenia Gravis diagnosis)

Labs: Required to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders:

SOLIRIS ORDERS

Adult Dosing

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

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

Required

☐ **Yes** ☐ **No** **Patient has had the meningococcal vaccine.**

☐ **Yes** ☐ **No** **Prescriber is enrolled in the Soliris REMS Program**

Optional: Patient may enroll in One Source by calling (888)-765-4747

Hypersensitivity/Anaphylaxis Response Protocol PRN

COMPLETE PRESCRIBER INFORMATION IN SECTION BELOW

Prescriber Name:	NPI#:	Office#:	Fax#:
Address:	City:	State:	Zipcode:

SIGNATURE OF LICENSED PRESCRIBER (REQUIRED TO VALIDATE PRESCRIPTION)

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Prescriber's Signature:

X_____

☐ DAW(Dispense as Written)

Date: _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.