Soliris (ECULIZUMAB)

INFUSION ORDERS

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

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

MEDICAL INFORMATION

Diagnosis: ☐ Paroxysmal nocturnal hemoglobulinuria (PNH) ICD-10 Code: _____

☐ Atypical hemolytic syndrome (aHUS) 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

Labs 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

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Prescriber Insurance Information

Prescriber Name		**NPI#**		**Office #**		**Fax #**	
Address		**City**		**State**		**Zip Code**	

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

☐ DAW (Dispense as written).

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.

Date

Prescriber's Signature

X _____

Please fax all information to (877)993-3548 or call (832)939-8128 for assistance