SOLIRIS
(ECULIZUMAB)

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

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

Drug Therapy Information

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 ☐ Referral 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.

Patient has had the meningococcal vaccine ☐ Yes ☐ No

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

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 _____