LIFE SPECIALTY SOLUTIONS

SOLIRIS
(eculizumab)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Medication List 5. Most Recent Labs

6. Tried/Failed Therapies 7. Is referring provider enrolled in FDA REMS program? ☐ Yes ☐ No

8. Has the patient received the Meningitis vaccination? ☐ Yes ☐ No Date of completion: _____

PRIMARY DIAGNOSIS

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)
☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)
☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)
☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)
☐ Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: There are no recommended standard pre-meds for Soliris
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Generalized Myasthenia Gravis (gMG) – or – Atypical Hemolytic Uremic Syndrome (aHUS)

☐ Soliris 900mg IV every week x 4 doses, then 1200mg IV every 2 weeks starting at week 5
☐ Soliris_____mg IV every_____weeks

Paroxysmal Nocturnal Hemoglobinuria (PNH)

☐ Soliris 600mg IV every week x 4 doses, then 900mg IV every 2 weeks starting at week 5
☐ Soliris_____mg IV every_____weeks
☐ Other _____

FIRST DOSE?: ☐ Yes ☐ No ☐ Refill x12 months unless otherwise noted _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC
☑ Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
☐ Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE