

# Soliris Order Form



Fax completed form to: \_\_\_\_\_

PATIENT INFORMATION			
Patient Name:		Date of Birth:	Referral Date:
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Patient Diagnosis & ICD-10:			
Allergies:			
PROVIDER INFORMATION			
Physician Name:	Lic.#:	DEA #:	
Practice Name:	NPI#:		
Address:	City/State/Zip:		
Office Contact:	Phone:	Fax:	
Supervisory Physician (if applicable):			
PLEASE ATTACH			
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) Line access documentation/verification if applicable		Vaccine status (any vaccination) and documentation of any recent vaccinations Clinical documentation on any recent meningococcal infections Documentation of a meningococcal vaccination Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
NURSING & LAB ORDERS			
<b>Nurse Orders:</b> Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.			
<b>Flush Orders:</b> NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line			
<b>Lab Orders:</b>		<b>Lab Date &amp; Frequency:</b>	
PRESCRIPTION ORDERS			
<b>Anaphylaxis Kit:</b> (Check all that apply)	Epinephrine 0.3mg IM as needed Diphenhydramine _____ mg IV infusion as needed	Solu-cortef 250mg-500mg IV infusion as needed NS Hydration 500 ml IV infusion over 30 minutes as needed	Solu-Medrol 60mg - 125mg IV infusion as needed Other
<b>Pre-Medications:</b> (Check all that apply)	Acetaminophen _____ mg PO _____ minutes prior to infusion Diphenhydramine _____ mg PO ---OR--- IV infusion _____ minutes prior to infusion	Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion	Other
<b>Supply Orders:</b> All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose? Yes No If No, when was last dose given? _____ When is patient due for next dose? _____			
Is the prescriber enrolled in the Soliris REMS program? Yes No			
Soliris Induction (≥18 years of age)	<b>PNH</b> 600 mg IV infusion via gravity ---OR--- pump every 7 days for 4 weeks over 35 minutes <b>aHUS, gMG and NMOsD</b> 900 mg IV infusion via gravity ---OR--- pump every 7 days for 4 weeks over 35 minutes		NONE
Soliris Maintenance (≥18 years of age)	<b>PNH</b> 900 mg IV infusion via gravity or pump every 2 weeks starting week 5 over 35 minutes <b>aHUS, gMG and NMOsD</b> 1,200 mg IV infusion via gravity or pump every 2 weeks starting week 5 over 35 minutes		_____
Soliris Induction (<18 years of age)	<b>aHUS</b> For patients 5-10kg administer 300mg IV infusion via gravity ---OR--- pump once weekly X 1 dose over 1 to 4 hours For patients 10-20kg administer 600mg IV infusion via gravity ---OR--- pump once weekly X 1 dose over 1 to 4 hours For patients 20-30kg administer 600mg IV infusion via gravity ---OR--- pump once weekly X 2 doses over 1 to 4 hours For patients 30-40kg administer 600mg IV infusion via gravity ---OR--- pump once weekly X 2 doses over 1 to 4 hours For patients >40kg administer 900 mg IV infusion via gravity ---OR--- pump once weekly X 4 doses over 1 to 4 hours		NONE
Soliris Maintenance (<18 years of age)	<b>aHUS</b> For patients 5-10kg administer 300 mg IV infusion via gravity ---OR--- pump starting at week 2 then 300mg every 3 weeks over 1 to 4 hours For patients 10-20kg administer 300 mg IV infusion via gravity ---OR--- pump starting at week 2 then 300mg every 2 weeks over 1 to 4 hours For patients 20-30kg administer 600 mg IV infusion via gravity ---OR--- pump starting at week 3 then 600mg every 2 weeks over 1 to 4 hours For patients 30-40kg administer 900mg IV infusion via gravity ---OR--- pump starting at week 3 then 900mg every 2 weeks over 1 to 4 hours For patients >40kg administer 1,200mg IV infusion via gravity ---OR--- pump starting at week 5 then 1,200mg every 2 weeks over 1 to 4 hours		_____
OTHER			_____
<b>By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.</b>			

Prescriber's Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_  
Dispense as Written

Prescriber's Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_  
Substitution Permitted

