Local Infusion

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SOLIRIS (ECULIZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________________ DOB: ______________

Mobile Number: ______________________ Patient Weight: ______________________

Allergies: ____

DIAGNOSIS (Provider must specify)

- ❑ Myasthenia Gravis (without acute exacerbation), ICD 10: G70.00
- ❑ Myasthenia Gravis with acute exacerbation, ICD 10: G70.01
- ❑ Neuromyelitis Optica Spectrum Disorder, ICD 10: G36.0
- ❑ Other: ____

PROVIDER INFORMATION

Provider Name (print name): ______________________ Provider NPI: ______________

Signature: ______________________________ Date: ______________

Contact Name: ______________________ Phone: ______________ Fax: ______________

Email Address: ____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

- ❑ Acetaminophen (Tylenol) 500 mg PO
- ❑ Benadryl 25mg PO
- ❑ Famotidine 20 mg IV
- ❑ Cetirizine (Zyrtec) 10 mg PO
- ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP
- ❑ Other: ______________________ Dose: ______________ Route: ______________

MEDICATION

MEDICATION	DOSE	ROUTE
Soliris	❑ Initial: 900 mg weekly X 4 weeks, 1200 mg week 5, then 1200 mg every 2 weeks thereafter. ❑ Maintenance: 1200 mg every 2 weeks ❑ Other: ______________	❑ IV

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): ______________

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ CT: 203.433.0621 ❑ ME: 207.407.7272 ❑ NH: 603.217.5371 ❑ NJ: 201.581.4521

Order valid for 1 year from date of signature unless otherwise specified here: ______________