

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

Famotidine 20 mg IV

Methylprednisolone (Solu-Medrol) 125 mg IVP

Benadryl 25mg PO

Cetirizine (Zyrtec) 10 mg PO

Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE
Soliris	<input type="checkbox"/> Initial: 900 mg weekly X 4 weeks, 1200 mg week 5, then 1200 mg every 2 weeks thereafter. <input type="checkbox"/> Maintenance: 1200 mg every 2 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> IV

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

LABS / SPECIAL INSTRUCTIONS