Soliris Infusion Order

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ___/___/___ Treatment Location: _____

***Please fax a copy of the following patient information:**

- ☐ Demographics
- ☐ Insurance Information
- ☐ Current Lab Results
- ☐ H & P Relevant to Diagnosis
- ☐ Current Medications
- ☐ Antibody Test Results

PATIENT INFORMATION

Patient Name: _____

DOB: ___/___/___

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ___/___/___

Phone: (___) ___-____ Fax: (___) ___-____

Office Address: _____

Contact Person: _____

SOLIRIS (ECULIZUMAB) IV DOSAGE

☐ **Dosage for aHUS, Myasthenia Gravis, and NMO**
900 mg once weekly for 4 weeks, 1200 mg on week 5, then 1200 mg every 2 weeks therafter

☐ **Dosage for PNG**
600 mg once weekly for 4 weeks, 900 mg on week 5, then 900 mg every 2 weeks therafter

☐ **Other**
_____ mg every _____

***Must be enrolled and authorized in the Soliris-REMS Program**