Soliris

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.

Demographics and insurance. Relevant, recent office notes including tried and failed meds. Current medication list. Current CBC & CMP.

Positive AChR Antibody test (NMOSD) or Positive AQP4 Antibody test (Myasthenia Gravis)

Meningococcal Vaccination: Must initiate vaccine at least 2 weeks prior to first dose

MenACWY (2 Doses) Menveo or Menactra Date of 1st/2nd dose:_____

AND MenB-4C (2 Doses) Bexsero Date of 1st/2nd dose:_____

OR MenB-FHbp (3 Doses) Trumenba Date of 1st/2nd/3rd dose:_____

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis:
- ☐ G70.00 Myasthenia gravis without (acute) exacerbation
- ☐ G70.01 Myasthenia gravis WITH (acute) exacerbation
- ☐ D59.5 PNH ☐ D59.32 aHUS ☐ G36.0 NMOSD

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Immunize patients with meningococcal vaccines at least 2 weeks prior to administering the first dose.

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

SOLIRIS DOSAGE

Date of Last Treatment, If Continuation: _____

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

☐ **Dosage for PNH**
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**

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.