Soliris

INFUSION FOR HEALTH

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, Meningococcal Vaccine

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ G70.00 ☐ G70.01 ☐ D59.5 PNH ☐ D59.32 aHUS ☐ G36.0 NMOSD ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI

☑ Meningococcal Vaccines Conjugate and Serogroup B (list dates of both MenB and MenACWY & attach clinicals):

_____

☑ Patients and prescribers must be enrolled and certified in the Ultomiris and Soliris REMS

PRE-MEDICATION ORDERS

Pre-Medications not usually indicated.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other _____ ☐ every _____

☐ 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.

THERAPY ADMINISTRATION

☑ Soliris in 0.9% Sodium Chloride ☑ IV Infusion

Dose:

For PNH

☐ **Induction Dose:** 600 mg once weekly for 4 weeks, then 900 mg week 5

☐ **Maintenance Dose:** 900 mg every 2 weeks thereafter

For aHUS, gMG, and NMOSD

☐ **Induction Dose:** 900 mg once weekly for 4 weeks, then 1200 mg week 5

☐ **Maintenance Dose:** 1200 mg every 2 weeks thereafter

☐ Monitor patients for 1 hour after completion of infusion

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

_____ _____ _____
Provider Name (Print) Provider Signature Date

☐ ***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.***