SOLIRIS (eculizumab)

○ New Prescription/Referral
○ Prescription Refill

# of Refills:

Rx:

Patient Name: | **Patient Weight: kg** | **DOB:**

SOLIRIS

*PNH Diagnosis	*aHUS, gMG, and NMOSD Diagnosis
☐ 600mg IV infusion Qweek for the 1st 4 weeks, then	☐ 900mg IV infusion Qweek for the 1st 4 weeks, then
☐ 900mg IV infusion as a fifth dose 1 week later, then	☐ 1200mg IV infusion as a fifth dose 1 week later, then
☐ 900mg IV infusion Q 2weeks.	☐ 1200mg IV infusion Q 2weeks.

For other orders, please enter here:

Pre-Medication:

☐ Solumedrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Others:

☐ Tylenol _____mg PO
○ 650mg ○ 975mg

☐ Benadryl _____mg
☐ 25mg ☐ IV
☐ 50mg ☐ PO

ANA Kit Protocol:

☐ OK to use

Dx:

OTHERS (Dx + ICD Code 10):

N P I #:

Physician Signature

Date: (Valid for 1 year)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: | **CLINIC:**

Contact Information: **Phone:** **Email:**
Fax: **Other:**

Office Mailing Address:

Please include the following

☐ Patient demographics & Insurance attached
☐ Diagnosis (supporting)
☐ History and Physical
☐ Lab Results
☐ Clinical progress notes
☐ Medication List
☐ Other Test Results
☐ Meningococcal Vaccinations - both Men B & Men ACWY
☐ Complete Metabolic Panel
☐ MG-ADL Score_____
☐ MGFA Classification
☐ Postive AchR (gMG)
☐ Postive AQP4