

***Patient Insurance & ID (front and back) are needed**

SOLIRIS (eculizumab)

☐ New Prescription/Referral

☐ Prescription Refill

of Refills:

Rx:

Patient Name:

Patient Weight:

kg

DOB:

SOLIRIS

***PNH Diagnosis**

- ☐ 600mg IV infusion Qweek for the 1st 4 weeks, then
☐ 900mg IV infusion as a fifth dose 1 week later, then
☐ 900mg IV infusion Q 2weeks.

***aHUS, gMG, and NMOSD Diagnosis**

- ☐ 900mg IV infusion Qweek for the 1st 4 weeks, then
☐ 1200mg IV infusion as a fifth dose 1 week later, then
☐ 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):

NPI #:

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