

ECULIZUMAB (SOLIRIS®) PRESCRIBER ORDER FORM		
FAX COMPLETED FORM, INSURANCE INFORMATION, CLINICAL DOCUMENTATION (LATEST NOTES & LABS) to: (757) 466-1128		
<input type="checkbox"/> NEW PATIENT OR <input type="radio"/> Drug Change <input type="radio"/> Dose Change <input type="radio"/> Interval Change		
Patient Name:	Date of Birth:	
Phone:	Gender:	
Address:		
Allergies:		
Height: <input type="checkbox"/> in <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kg	
CLINICAL INFORMATION		
Primary Diagnosis Description:	ICD-10 Code:	
Meningococcal Vaccination Status: <input type="checkbox"/> Primary vaccination series completed – Date: _____ <input type="checkbox"/> MenACWY booster completed – Date: _____ <input type="checkbox"/> MenB booster completed – Date: _____		
PRESCRIPTION		
Eculizumab (Soliris®) refill as directed x 1 year		
Induction Dose:	<input type="checkbox"/> Infuse 600mg IV over at least 35 minutes weekly x 4 weeks <input type="checkbox"/> Infuse 900mg IV over at least 35 minutes weekly x 4 weeks <input type="checkbox"/> Other: _____	
Maintenance Dose:	<input type="checkbox"/> Infuse 900mg IV over at least 35 minutes on week 5, then every 2 weeks thereafter <input type="checkbox"/> Infuse 1200mg IV over at least 35 minutes on week 5, then every 2 weeks thereafter <input type="checkbox"/> Infuse _____ mg IV over at least 35 minutes 2 weeks <input type="checkbox"/> Other: _____ Max infusion time not to exceed 2 hours.	
ANCILLARY ORDERS		
Pre-Medication Orders <input type="checkbox"/> Acetaminophen 650mg PO 30 minutes before infusion. <i>Patient may decline.</i> <input type="checkbox"/> Diphenhydramine 25mg PO/IV 30 minutes before infusion. <i>Patient may decline.</i> <input type="checkbox"/> Cetirizine 10mg IV 30 minutes before infusion. <input type="checkbox"/> Other: _____		
PRN Hypersensitivity Meds: <ul style="list-style-type: none"> • Epinephrine 0.3mg • Solu-Cortef 100mg • Solu-Medrol 125mg • Diphenhydramine 25-50mg • NS 500 ML (>30kg) Refill above ancillary orders as directed x 1 year.		
<i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>		
Prescriber Signature:	Date:	
PRESCRIBER INFORMATION		
Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State, Zip:	Office Contact:	
<small>CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of the information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.</small>		