Site of Care
☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

SOLIRIS (ECULIZUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number: _____

Patient Weight: _____ Patient Height: _____ Allergies: _____

Other Medications: _____

DIAGNOSIS (Provider must specify)

☐ Myasthenia Gravis without acute exacerbation, ICD10: G70.00

☐ Myasthenia Gravis with acute exacerbation, ICD10: G70.01

☐ Neuromyelitis Optica Spectrum Disorder (NMOSD), ICD10: G36.0

☐ Other: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Bendaryl 25 mg PO ☐ Methylprednisolone (Solu-Medrol) ____ mg IVP

☐ Other: _____ Dose: _____ Route: _____

☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE
Soliris	☐ Initial: 900 mg weekly x 4 weeks, 1200 mg week 5, then 1200 mg every 2 weeks thereafter. ☐ Maintenance: 1,200 mg every 2 weeks ☐ Other: _____	**IV**

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS/SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

PROVIDER INFORMATION

Provider Name: _____ Provider NPI: _____ Contact: _____

Phone: _____ Fax: _____ Email Address: _____

Signature: _____ Date: _____