DELIVERIT PHARMACY
Infusion & Specialty

SOLIRIS (ECULIZUMAB) Infusion Orders

T: 832.939.8137 **Address: 12144 Dairy Ashford Rd., Suite 100, Sugar Land, TX 77478** **F: 832.939.8128**

PATIENT INFORMATION

Patient Name: _____ Social Sec #: _____ Weight: ____ lbs

D.O.B: _____ Sex: Male ____ Female _____ Height: ____ lbs

Phone: _____

Address: _____ City: _____ State: ____ Zip Code: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Diagnosis

- ☐ Paroxysmal nocturnal hemoglobulinuria (PNH) ICD-10 Code:_____
- ☐ Atypical hemolytic syndrome (aHUS) ICD-10 Code:_____
- ☐ Myasthenia Gravis (gMG) with AchR antibody positive ICD-10 Code:_____

Allergies: _____

- ☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis and including past tried and/or failed therapies, intolerance, outcomes or contradictions to conventional therapy
- ☐ Positive serologic test for anti-AchR antibodies (if Myasthenia Gravis diagnosis)

Labs: Required to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

SOLIRIS ORDERS

Adult Dosing

☐ **PNH**

600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every 2 weeks thereafter.

☐ **aHUS and gMG**

900mg IV weekly for the first 4 weeks, followed by 1200mg for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter.

Required

☐ **Yes** ☐ **No** **Patient has had the meningococcal vaccine.**

☐ **Yes** ☐ **No** **Prescriber is enrolled in the Soliris REMS Program**

Optional: Patient may enroll in One Source by calling (888)-765-4747

Hypersensitivity/Anaphylaxis Response Protocol PRN

PHYSICIAN INFORMATION

By signing this form and utilizing ur services, you are authorizing DeliverIt Pharmacy and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____