Soliris® Referral Form

IVCareOptions

PHONE: 1-800-277-7302 FAX: 1-866-374-6663

Demographics Information: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ ☐ Cell Alternate Phone #: _____ ☐ Cell

Height: _____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN: _____

Allergies: _____ ☐ **NKDA**

Diagnosis Information:

☐ Myasthenia Gravis G70.01 ☐ Other Diagnosis/ICD10Code_____

Date Infusion to Begin: _____

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: _____

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: _____

List of Failed Therapies: _____

Assessment Questions: *Please Provide Appropriate Documentation* TB status if known: _____

Diabetes? ☐ Yes ☐ No HTN? ☐ Yes ☐ No Cardiac History? ☐ Yes ☐ No Difficulty Breathing? ☐ Yes ☐ No

Requires Oxygen? ☐ Yes ☐ No Confusion /Disorientation? ☐ Yes ☐ No Neuro History? ☐ Yes ☐ No

Date received quadrivalent meningococcal conjugate (MenACWY)_____ Date Received serogroup B (MenB) _____

Soliris (eculizumab)®: J1300 ☐ ***Provider Reviewed FDA/REMS recommendations***

☐ **Initial Dose:** 900mg IV every week for the first 4 weeks followed by 1200mg IV for the 5th dose a week later, then the maintenance dose of 1200mg IV every 2 weeks for _____ months

☐ **Maintenance dose:** 1200mg IV every 2 weeks for _____ months

Pre-Medications: **Patient to provide and take 30 minutes prior to infusion**

☐ Benadryl 25 MG PO x1 ☐ Benadryl 50 mg PO x1

☐ Acetaminophen 325 mg PO x1 ☐ Acetaminophen 650 mg PO x1

☐ Other Pre-medication: _____

Access: ☐ **PIV** ☐ **PORT** ☐ **PICC** **Route:** ☐ **IV**

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5mL x 10

PORT – NS 10mL x 10, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10mL x 10, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 1 per infusion

Catheter Care Supplies (A4221) – 1 per week

Infusion Pump (E0781)

Nursing services to administer

For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures

Physician/PA signature: _____

NPI # _____ Phone Number _____

Office Address: _____ City: _____ St GA Zip: _____

Printed Name:_____ Contact Name: _____

Please fax this form to our Intake Department along with a copy of Patient's Insurance Card, Demographic information, H & P, Office Visit notes - including supporting documentation for failed therapies, and Up to Date Medication List.

01/21 TSP