

# Soliris® Referral Form



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: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	<b>List of Failed Therapies:</b> _____

**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 5<sup>th</sup> 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: \_\_\_\_\_

<p><b>Access:</b> <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC <b>Route:</b> <input type="checkbox"/> IV</p> <p>Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency</p> <p>PIV – NS 5ml: Qty 10</p> <p>PORT – NS 10ml: Qty 10, Heparin 5mL 100units/mL x 1 per infusion.</p> <p>PICC – NS 10ml: Qty 10, Heparin 5mL 10units/mL x 1 per infusion</p>	<p><b>Supplies:</b> (please strike through if not required)</p> <p>Administration Supplies (A4222) – 1 per infusion</p> <p>Catheter Care Supplies (A4221) – 1 per week</p> <p>Infusion Pump (E0781)</p> <p>Nursing services to administer</p>
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*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.**

05/21 TSP