SOLIRIS ORDER

Please complete ALL fields and fax to 817-553-1393. An incomplete form will delay the processing/scheduling of the patient. Thank you for your referral and allowing us to partner with you in the care of your patient. Please call 817-553-1325 with any questions.

Patient Name: _____DOB: _____

Phone: _____Allergies: _____

Weight: _____ ❑ lbs/❑ kg

Primary Diagnosis: _____ ICD-10 Code: _____

Please send all of the following items to complete your referral:

- ❑ This completed order form
- ❑ Patient demographics and insurance information
- ❑ HPI/Clinical Documentation to support primary Diagnosis– ICD-10.
- ❑ Any other relevant lab work, scans or test results
- ❑ MenA and MenB vaccination records

Prescription: (*ORDER EXPIRES IN ONE YEAR)

- Start Peripheral IV Saline lock.
- Flush IV line with 3 to 10ml 0.9% Sodium Chloride before and after IV medication administration.

❑ Initial: Soliris 900 mg IV x4 weeks. Soliris 1200 mg IV on 5th week. Then Soliris 1200 mg IV thereafter every 2 weeks.

❑ Maintenance: Soliris 1200 mg IV every 2 weeks. Last dose of Soliris was _____.

Ordering Provider Information

Name _____

Address _____

_____

NPI # _____

Signed _____

Office Contact Information

Name _____

Phone ( ) _____-_____

Fax ( ) _____-_____

Email _____

Date _____ /_____ /_____