SOLIRIS®

Please Fax Completed Form To: 888-340-3699
Please Send a Copy of The Patient's Insurance Cards (Front & Back)
Please Send a Copy of The Patient's Up-to-Date Clinical Notes

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: ______________________ DOB: __________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________ Alt. Phone: ______________
Email: ______________________ SS#: ______________
Gender: ☐ M ☐ F Weight: ________(lbs) Ht: ______________
Allergies: ______________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________
State License: ______________________
NPI #: ______________ Tax ID: ______________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________ Fax: ______________
Office Contact: ______________ Phone: ______________

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: ______________________
Plan #: ______________________
Group #: ______________________
RX Card (PBM): ______________________
BIN: ______________ PCN: ______________

Secondary Insurance (If Applicable): ______________________
Plan #: ______________________
Group #: ______________________
RX Card (PBM): ______________________
BIN: ______________ PCN: ______________

CLINICAL INFORMATION

Primary ICD-10 Code (Please Specify Diagnosis): ______________________
Secondary ICD-10 Code (Please Specify Diagnosis): ______________________
MG-ADL* score: __________ Has the patient received Meningitis vaccination(s)? ☐ Yes ☐ No Date of vaccination(s): ______________ ☐ Please check this box if the patient has declined vaccination Reason: ______________________ Adverse reactions with previous Soliris treatments? ☐ No ☐ Yes *If yes*, Reason/Date: ______________________ ☐ Please check to confirm: The patient is enrolled in the SOLIRIS REMS program; The patient has been counseled about the risks of meningococcal infection; The patient has received information and a Patient Safety Card about the symptoms and risks of meningococcal infection.

SOLIRIS® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: __________ Date of Last Injection/Infusion: __________

Medication	Strength	Dose/Frequency	Refills
☐ Soliris® (eculizumab)	☐ 300mg/30mL	☐ Loading dose: __________mg IV every __________ weeks for weeks. ☐ Maintenance dose: __________mg IV every __________ weeks. ☐ Other:______________________	______________

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg ☐ 25mg IV/PO	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Diphenhydramine	☐ 50mg IV/PO ☐ 40mg ☐ 100mg	☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 125mg ______________	☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion
☐ ______________		______________________

INFUSION REACTION ORDERS

Mild reaction protocol:
☒ Diphenhydramine 25mg IV, one time, for pruritus.
If symptoms worsen, see orders for moderate to severe reactions.

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Moderate reaction protocol:

☒ Acetaminophen 650mg PO, one time, for pyrexia or rigors

☒ Diphenhydramine 50mg IV, one time, for pruritus or urticaria

☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

☒ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)

☒ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis

☒ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis

☒ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms

☒ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:	Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:
☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion	☒ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:	PICC:	Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:
☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	☒ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush	☒ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused**

SIGNATURE

We hereby authorize Infuse IQ LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X____ Date: ____________________

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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