Sarah Bush Lincoln

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Atypical Hemolytic Uremic Syndrome (aHUS)	ICD 10 Code: D59.3
☐ Myasthenia Gravis, Acetylcholine Receptor Antibody Positive	ICD 10 Code: G70.00
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5
☐ Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code: G36.0

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary diagnosis
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis)	☐ Aquaporin 4 Antibody Test Results (if NMO)
☐ Pregnancy Test (if applicable)	☐ Documentation of meningococcal vaccines

Is your patient enrolled in the Soliris-REMS program? ☐ Yes ☐ No

List Tried & Failed Therapies (if Myasthenia Gravis):

1)

2)

3)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Dosing for aHUS, Myasthenia Gravis, and NMO	☐ Soliris 900mg IV once weekly for 4 weeks, followed by 1200mg IV at week 5, then 1200 mg IV every 2 weeks thereafter ☐ Soliris _____ mg IV every _____
Dosing for PNH	☐ Soliris 600mg IV once weekly for 4 weeks, followed by 900mg IV at week 5, then 900mg IV every 2 weeks thereafter) ☐ Soliris _____ mg IV every _____

Refills: ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS

PRESCRIBER INFORMATION

Prescriber name :

Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

INFUSION ORDERS - SOLIRIS (ECULIZUMAB)

Clinics Scan to: Physician Orders