



Soliris® Referral Form



PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com Initial Order Reorder

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: _____	List of Failed Therapies: _____

Assessment Questions:

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: _____

<p>Access: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <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 3</p> <p>PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.</p> <p>PICC – NS 10ml: Qty 3, Heparin 5mL 10units/mL x 1 per infusion</p>	<p>Supplies: (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 medications</p> <p><i>Administer the anaphylaxis protocol for adverse reactions</i></p>
--	---

Provider signature: _____

NPI # _____ Phone _____ Fax _____

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

Printed MD Name: _____ Contact Name: _____

Demographic information Patient Ins. Card H & P Office notes Failed therapies in documentation

Up to date medication list