

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

D59.30 Hemolytic Uremic Syndrome (aHUS) G70.00 Myasthenia Gravis without acute exacerbation

D59.5 Paroxysmal nocturnal hemoglobinuria (PNH) G70.01 Myasthenia Gravis with acute exacerbation

G36.0 Neuromyelitis optica (NMOSD) {SOLIRIS® only for NMOSD}

ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

Insurance Information List of Medications Tried & Failed Therapies Most Recent History & Physical anti-AChR or anti-AQP4 Status Meningococcal vaccine records

MEDICATION ORDER

SOLIRIS® or biosimilar (BKEMV) may be used according to payor guidelines.

To restrict substitution, indicate required brand here: _____

For PNH

LOADING: Eculizumab 600mg IV per protocol weekly for 4 weeks, followed by 900mg IV at week 5

MAINTENANCE: Eculizumab 900mg IV per protocol every 2 weeks

*Maintenance dosing scheduled 2 weeks following last loading dose at week 5

FOR aHUS, gMG, NMOSD (BKEMV not indicated for NMOSD)

LOADING: Eculizumab 900mg IV per protocol weekly for 4 weeks, followed by 1200mg IV at week 5

MAINTENANCE: Eculizumab 1200mg IV per protocol every 2 weeks

*Maintenance dosing scheduled 2 weeks following last loading dose at week 5

OTHER: _____

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 60 minutes following each infusion. Administer per protocol.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRE-MEDICATIONS

PO

Acetaminophen: 650 mg
 Cetirizine: 10 mg
 Diphenhydramine: 25 mg

IV

Methylprednisolone: 125 mg
 Diphenhydramine: 25 mg

OTHER: _____ PO IV

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN