

Patient Information

Patient Name:	Patient DOB:	Patient Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Patient Email:	Insurance:	

Additional Information Needed

- | | | |
|---|--|---|
| <input type="checkbox"/> Fax front/back of insurance card | <input type="checkbox"/> Fax clinical/progress notes | <input type="checkbox"/> Fax labs |
| <input type="checkbox"/> Fax patient demographics | <input type="checkbox"/> Fax current medication list | <input type="checkbox"/> Fax TB and Hep B results |

Diagnosis and Clinical Information
Diagnosis (ICD-10):

- D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)
 D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)
 G36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD)
 G70.00 Myasthenia Gravis (gMG) without Acute Exacerbation
 G70.01 Myasthenia Gravis (gMG) with Acute Exacerbation
 Other: Code: _____ Description: _____

 Prescriber enrolled in Soliris REMS Program? Yes No

 Patient Received Meningococcal Vaccine? * Yes No

Date of Vaccination: _____

** Meningococcal Vaccine recommended to be given at least two weeks prior to first dose of Soliris.*

Clinical Information:

- New Therapy Induction Therapy Change Therapy Continuation
 Patient Weight: _____ lbs / _____ kg
 Patient Height: _____ in / _____ cm
 Allergies: _____
 Therapies Tried and Failed: _____
 Does patient have history of adverse reaction to Soliris? Yes No
 Is patient Anti-Acetylcholine Receptor (AChR) positive? (if gMG diagnosis) Yes No
 Is patient Anti-Aquaporin Antibody positive? (if NMOSD diagnosis) Yes No

 If "Yes," send test results.

 If "Yes," send test results.

Lab Orders

- CBC CMP ESR CRP
 Other: _____

Lab Orders to be done by

- Oklahoma Infusion Services
 Referring Provider

Prescription Information

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Soliris | Initial Dose:
<input type="checkbox"/> 600mg weekly for first 4 weeks; then 900mg for 5 th dose 1 week later
<input type="checkbox"/> 900mg weekly for first 4 weeks; then 1200mg for 5 th dose 1 week later | Maintenance Dose:
<input type="checkbox"/> 900mg every 2 weeks after Initial Dose
<input type="checkbox"/> 1200mg every 2 weeks after Initial Dose |
|----------------------------------|---|---|

Pre-Medication Orders

- | | |
|--|--|
| <input checked="" type="checkbox"/> Solu-Cortef 50-100mg SIVP | <input checked="" type="checkbox"/> Benadryl 25mg PO PRN |
| <input checked="" type="checkbox"/> Tylenol tablet 500-1000mg PO PRN | <input type="checkbox"/> Other: _____ |

Standing Orders for Adverse Reactions

- | | |
|--|---|
| <input checked="" type="checkbox"/> Stop infusion and initiate NS bolus | <input checked="" type="checkbox"/> Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis |
| <input checked="" type="checkbox"/> Notify supervising physician and ordering provider | <input checked="" type="checkbox"/> Oxygen 2-5L nasal cannula |
| <input checked="" type="checkbox"/> Solu-Cortef 100mg SIVP signs of adverse reaction | <input checked="" type="checkbox"/> Albuterol 2.5mg inhaled PRN for chest tightness |
| <input checked="" type="checkbox"/> Benadryl 25mg SIVP for hives or bronchial inflammation | <input type="checkbox"/> Other: _____ |

Prescriber Information


Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:


Prescriber's Signature: _____


Date: _____

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

Please fax form to: 405-726-9849

 **Edmond**
 1701 Renaissance Blvd, Ste 110
 Edmond, OK 73013
Phone: (405) 844-4978

 **Enid**
 825 E Owen K Garriott Rd
 Enid, OK 73701
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 **Tulsa**
 6135 S 90th E Ave
 Tulsa, OK 74133
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