OKLAHOMA INFUSION SERVICES

Soliris Order Form

Please fax form to: 405-726-9849

Patient Information

Patient Name:	Patient DOB:	Patient Phone:	Gender: M ☐ F ☐
Patient Address:	Patient Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ 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: _____

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 ☐ If "Yes," send test results.
☐ Is patient Anti-Aquaporin Antibody positive? (if NMOSD diagnosis) ☐ Yes ☐ No ☐ If "Yes," send test results.

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.*

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP
☐ Other: _____

Lab Orders to be done by

☐ Oklahoma Infusion Services
☐ Referring Provider

Prescription Information

☐ Soliris

Initial Dose:
☐ 600mg weekly for first 4 weeks; then 900mg for 5th dose 1 week later
☐ 900mg weekly for first 4 weeks; then 1200mg for 5th dose 1 week later

Maintenance Dose:
☐ 900mg every 2 weeks after Initial Dose
☐ 1200mg every 2 weeks after Initial Dose

Pre-Medication Orders

☒ Solu-Cortef 50-100mg SIVP
☒ Tylenol tablet 500-1000mg PO PRN
☒ Benadryl 25mg PO PRN
☐ Other: _____

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus
☒ Notify supervising physician and ordering provider
☒ Solu-Cortef 100mg SIVP signs of adverse reaction
☒ Benadryl 25mg SIVP for hives or bronchial inflammation
☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Oxygen 2-5L nasal cannula
☒ Albuterol 2.5mg inhaled PRN for chest tightness
☐ 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.

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