Soliris Referral Form

amerita specialty infusion services

EVENTUS RX an amerita company

Fax completed form to: _____

PATIENT INFORMATION

Patient Name:	Date of Birth:	Referral Date:
Address:		City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:
Secondary Contact:	Height: Weight:	☐ Male ☐ Female
Patient Diagnosis & ICD-10:		
Allergies:		

PROVIDER INFORMATION

Physician Name:	Lic.#:	DEA #:
Practice Name:		NPI#:
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		

PLEASE ATTACH

- ☐ Patient demographics & front/back copy of all insurance cards (prescription & medical)
- ☐ Recent office visit notes, history & physical, lab & pertinent procedure results
- ☐ Current medication list & list of prior medications tried and failed (with dates)
- ☐ Line access documentation/verification if applicable
- ☐ Vaccine status (any vaccination) and documentation of any recent vaccinations
- ☐ Clinical documentation on any recent meningococcal infections
- ☐ Documentation of a meningococcal vaccination
- ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS

Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion.
Flush Orders: *NaCl 0.9%* - 5-10mL flush pre and post infusion and as needed *Heparin* - ☐ 10units/mL ***---OR---*** ☐100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line
Lab Orders: **Lab Date & Frequency:**

PRESCRIPTION ORDERS

Anaphylaxis Kit: (Check all that apply)
☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed
☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other

Pre-Medications: (Check all that apply)
☐ Acetaminophen _____mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____mg IV infusion _____minutes prior to infusion
☐ Diphenhydramine _____ mg ☐ PO ***---OR---*** ☐ IV infusion _____minutes prior to infusion ☐ Other

Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given?_____ When is patient due for next dose?_____		
Is the prescriber enrolled in the Soliris REMS program? ☐ Yes ☐ No		
☐ Soliris Induction (≥18 years of age)	☐ **PNH** ☐ 600 mg IV infusion every 7 days for 4 weeks over 35 minutes ☐ **aHUS, gMG and NMOSD** ☐ 900 mg IV infusion every 7 days for 4 weeks over 35 minutes	NONE
☐ Soliris Maintenance (≥18 years of age)	☐ **PNH** ☐ 900 mg IV infusion every 2 weeks starting week 5 over 35 minutes ☐ **aHUS, gMG and NMOSD** ☐ 1,200 mg IV infusion every 2 weeks starting week 5 over 35 minutes	_____
☐ Soliris Induction (<18 years of age)	**aHUS** ☐ For patients 5-10kg administer 300mg IV infusion once weekly X 1 dose over 1 to 4 hours ☐ For patients 10-20kg administer 600mg IV infusion once weekly X 1 dose over 1 to 4 hours ☐ For patients 20-30kg administer 600mg IV infusion once weekly X 2 doses over 1 to 4 hours ☐ For patients 30-40kg administer 600mg IV infusion once weekly X 2 doses over 1 to 4 hours ☐ For patients >40kg administer 900 mg IV infusion once weekly X 4 doses over 1 to 4 hours	NONE
☐ Soliris Maintenance (<18 years of age)	**aHUS** ☐ For patients 5-10kg administer 300mg IV infusion starting at week 2 then 300mg every 3 weeks over 1 to 4 hours ☐ For patients 10-20kg administer 300mg IV infusion starting at week 2 then 300mg every 2 weeks over 1 to 4 hours ☐ For patients 20-30kg administer 600mg IV infusion starting at week 3 then 600mg every 2 weeks over 1 to 4 hours ☐ For patients 30-40kg administer 900mg IV infusion starting at week 3 then 900mg every 2 weeks over 1 to 4 hours ☐ For patients >40kg administer 1,200mg IV infusion starting at week 5 then 1,200mg every 2 weeks over 1 to 4 hours	_____
☐ OTHER		_____

By signing this form and utilizing our services, you are authorizing EventusRx to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted