SOLIRIS®

(eculizumab) or biosimilars EPYSQLI® & BKEMV®

Advanced Infusion Care Centers®

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Myasthenia gravis without (acute) exacerbation (G70.00)
☐ Myasthenia gravis with (acute) exacerbation (G70.01)
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH) (D59.5)
☐ Atypical Hemolytic Uremic Syndrome (aHUS) (D59.3)
☐ Neuromyelitis Optica Spectrum Disorder (NMOSD) (G36.0)
☐ Other: _____

PRESCRIPTION

- Has the patient completed the full meningococcal vaccination series ☐ Y ☐ N
- If no, the patient will receive first dose of SOLIRIS at least two weeks after the first dose of the vaccine series. If you want to hold SOLIRIS treatment until the patient has completed the full vaccine series, check here ☐

**Prophylactic antibiotic coverage is recommended if starting SOLIRIS prior to completion of the vaccine series. This is at the discretion of, and managed by, the referring provider.*

PNH

Initial:

☐ 600 mg IV weekly for the first 4 weeks, followed by 900 mg IV for the 5th dose 1 week later, then 900 mg IV every 2 weeks thereafter x 1 year

Maintenance:

☐ 900 mg IV every 2 weeks thereafter x 1 year

aHUS, gMG, and NMOSD

Initial:

☐ 900 mg IV weekly for the first 4 weeks, followed by 1200 mg IV for the fifth dose 1 week later, then 1200 mg IV every 2 weeks thereafter x 1 year

Maintenance:

☐ 1200 mg IV every 2 weeks x 1 year
☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Tried/Failed Therapies
- Most recent labs
- Medication List
- Is referring provider enrolled in the FDA REMS program? ☐ Yes ☐ No

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other: Please fax other adverse reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: No recommended standard pre-medications for this infusion.

☐ Provider Prescribed: _____

LINE CARE ORDERS

Start PIV/Access CVC

Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

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