

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____
Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):
 Primary Diagnosis: _____ Atypical Hemolytic Uremic Syndrome (aHUS) ICD-10 Code: D59.3 _____
 _____ Myasthenia Gravis (MG) ICD-10 Code: G70. _____
 _____ Neuromyelitis Optica Spectrum Disorders (NMOSD) ICD-10 Code: G36.0 _____
 _____ Paroxysmal nocturnal hemoglobinuria (PNH) ICD-10 Code: D59.5 _____
 _____ Other: _____ ICD-10 Code: _____
 Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:
 • Clinical MD Notes, labs, test supporting primary diagnosis
 • Positive Serologic test results if appropriate for diagnosis (e.g. NMOSD or MG)
 • Patient has had the appropriate meningococcal vaccines Yes No
 • Prescriber is enrolled in Soliris REM Program Yes No

Patient Weight: _____ lbs.
Patient Height: _____ in.

Lab Orders: _____

SOLIRIS® (eculizumab) J Code: J1300

4. Drug Order:
 PNH _____ # Refills (Recommend 15)
 Initial Dose Infuse 600 mg IV weekly for 4 weeks, followed by 900 mg IV the following week and then 900 mg IV every 2 weeks thereafter
 Maintenance Dose Infuse 900 mg IV every two weeks
 aHUS, gMG, NMOSD _____ # Refills (Recommend 15)
 Initial Dose Infuse 900 mg IV weekly for 4 weeks, followed by 1200 mg IV the following week and then 1200 mg IV every 2 weeks thereafter
 Maintenance Dose Infuse 1200 mg IV every 2 weeks

Pre-Medication Orders: Acetaminophen 650 mg PO administered 30 min prior to infusion *adjust to patient's needs
 Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.
 By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
 Dispense as written Substitution permitted
 Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337
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