INTRAMED Plus
infusion services

SOLIRIS®

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.
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	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	**COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**