



**HERITAGE**  
BIOLOGICS

**Eculizumab (Soliris) Patient Referral Form**

Admissions Fax # 844-878-6917

Admissions Phone # 855-WE-R-RARE (855-937-7273)

**Patient Demographics Information**

Patient Name		SSN#	DOB
Patient Address			
Primary Phone	Cellular Phone	Work Phone	
Emergency Contact Name, Relationship		Emergency Contact Phone Number	

**Additional Documentation Needed**

- Copy of insurance cards
- Patient face sheet w/demographics
- History and Physical
- CBC w/diff, BMP, & CMP
- Recent vitals including blood pressure
- Meningitis vaccine (REMS requirement)

**Patient Insurance Information**

Insurance Plan #1	Insurance Plan #2		
Plan Address	Plan Address		
Plan Phone & Fax Numbers	Plan Phone & Fax Numbers		
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

**Patient Clinical Information**

Gender	Height (inches)	Weight (lbs.)	Allergies (food/drug)
<input type="checkbox"/> M <input type="checkbox"/> F			

**Statement of Medical Necessity / Primary Diagnosis**

ICD10:	Description of diagnosis:

**Medication Information / Prescription and Orders**

<b>Medication:</b>  Soliris	<b>Directions:</b> Infuse IV per manufacturer guidelines <b>OR</b> over _____ hours. Titration rate according to package insert. Dilute Soliris dose in Sodium Chloride 0.9% to a final concentration of 5mg/mL.	*If subsequent treatment cycles only Date of last infusion:  Next dose due:
<input type="checkbox"/> Initial treatment cycle 900 mg IV weekly x4 weeks, followed by 1200 mg IV for 5th dose 1 week later, #QS, refills 0 <input type="checkbox"/> Subsequent treatment cycles 1200 mg IV every 2 weeks, #1 dose, refill x12mos <b>OR</b> <input type="checkbox"/> other _____		

**Line Access**

- RN to start peripheral IV or use existing CVC. RN to administer catheter flushing 2-10 mL IV as needed for infusion and line maintenance.
- 0.9% Sodium Chloride     Heparin 10 units/ml     Heparin 100 units/ml     0.9% Sodium Chloride Sterile (port)

**Quantity/Refills**

Dispense:  
quantity #QS + PRN refills unless otherwise noted  
 Other

**Adverse Reaction Orders**

In the event of an infusion reaction (ie: musculoskeletal pain, fevers, chills, rigors, headache) the following orders will be followed and physician will be notified.

- Mild reaction: Pause infusion for 10 minutes, resume infusion at previously tolerated rate.
- Moderate reaction: Pause infusion, administer Diphenhydramine 25 mg PO x1. If needed give additional dose of Diphenhydramine 25 mg PO. Notify Pharmacist. #QS
- Severe reaction (w/breathing problems): CALL 911, administer Epinephrine 0.3 mg IM.

**Prescriber Information**

Physician Name		Office Contact	
Practice Address		Practice Phone	
NPI#	License #	DEA#	
Physician Signature Required - Substitution Permitted		Date	Physician Signature Required - Dispense as Written
			Date