Eculizumab (Soliris) Patient Referral Form

Admissions Fax # 844-878-6917

Admissions Phone # 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 ☐M ☐F	Height (inches)	Weight (lbs.)	Allergies (food/drug)

Statement of Medical Necessity / Primary Diagnosis

ICD10: Description of diagnosis:

Medication Information / Prescription and Orders

Medication:

Soliris

Directions:

Infuse IV per manufacturer guidelines **OR** over _______ hours.
Titration rate according to package insert.
Dilute Soliris dose in Sodium Chloride 0.9% to a final concentration of 5mg/mL.

☐ Initial treatment cycle

900 mg IV weekly x4 weeks, followed by
1200 mg IV for 5th dose 1 week later, #QS, refills 0

☐ Subsequent treatment cycles

1200 mg IV every 2 weeks, #1 dose, refill x12mos **OR** ☐ other ___________

*If subsequent treatment cycles only
Date of last infusion:

Next dose due:

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.

Labs:

Frequency of Labs:

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