

Eculizumab (Soliris) Patient Referral Form

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	
Subscriber Name	DOB	Subscriber Name	DOB
Policy Number	Group ID	Policy Number	Group ID

Patient Clinical Information

Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (inches)	Weight (lbs.)	Allergies (food/drug)
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Statement of Medical Necessity / Primary Diagnosis

ICD10:	Description of diagnosis:
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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.	*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 OR <input type="checkbox"/> other _____		

Line Access

- RN to start peripheral IV or use existing CVAD. RN to administer catheter flushing and medications as directed.
- Sodium Chloride 0.9% 10 mL Flush: Flush with 2-10 mL sodium chloride 0.9% IV before and after medication administration or every 24 hours while IV access in place.
 - Sodium Chloride 0.9% 10 mL STERILE Flush: Flush with 5-10 mL STERILE sodium chloride 0.9% IV as needed for port access.
 - Heparin Lock 100U/mL 5 mL Flush: Lock with 5 mL heparin 100U/mL after each use or daily while port accessed.

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 dose.
If needed, give additional dose of Diphenhydramine 25 mg PO. Notify Pharmacist.
 - 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