Soliris®

Provider Order Form Rev. 10/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Hemolytic-uremic syndrome (aHUS), D59.3
☐ Paroxysmal nocturnal hemoglobinuria (PNH), D59.5
☐ Neuromyelitis optica [Devic], G36.0
☐ Myasthenia gravis without (acute) exacerbation, G70.00
☐ Myasthenia gravis with (acute) exacerbation, G70.01
☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE, DIRECTIONS, and DURATION
Soliris® (eculizumab)	**For PNH:** ☐ Induction and Maintenance: • Infuse 600 mg IV over minimum of 35 minutes once weekly x 4 weeks. • Infuse 900 mg IV over minimum of 35 minutes starting at Week 5, then every 2 weeks thereafter x 1 year. ☐ Maintenance Only: Infuse 900 mg IV over minimum of 35 minutes every 2 weeks x 1 year. **For aHUS, gMG and NMOSD:** ☐ Induction and Maintenance • Infuse 900 mg IV over minimum of 35 minutes once weekly x 4 weeks. • Infuse 1200 mg IV over minimum of 35 minutes starting at Week 5, then every 2 weeks thereafter x 1 year. ☐ Maintenance Only: Infuse 1200 mg IV over minimum of 35 minutes every 2 weeks x 1 year. ☐ Observe patient for 1 hour following completion of each IV administration

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time
☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO
☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP
☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician
☐ No labs ordered at this time
☐ CMP q _____ ☐ CBC with diff/platelets q _____
☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply.

☐ **REQUIRED:** Patient will have been immunized with a meningococcal vaccine at least 2 weeks prior to receiving the first dose of Soliris®.

☐ **REQUIRED:** Provider is enrolled in the Soliris® REMS program.

For Hemolytic-Uremic Syndrome (aHUS) only:

☐ Diagnosis of thrombocytopenic purpura (TTP) has been ruled out by ONE of the following:
- ☐ ADAMTS 13 activity level > 5%
- ☐ Patient has failed a trial of plasma exchange

☐ Absence of Shiga toxin-producing E. coli related infection is documented

For Paroxysmal Nocturnal Hemoglobinuria (PNH) only:

☐ Deficiency of glycosylphosphatidylinositol-anchored proteins (GPI-APs) documented by flow cytometry with ONE of the following:
- ☐ ≥ 5% PNH type III red cells
- ☐ ≥ 51% of GPI-anchored protein deficient polymorphonuclear cells

☐ Patient has required at least one transfusion -OR- has a documented history of a thromboembolic event

☐ Patient has documented LDL level at 1.5 times the upper limit of normal range

Patient Name: _____ DOB: _____

For generalized Myasthenia Gravis (gMG) only:

- ☐ Presence of anti-acetylcholine receptor (AchR) antibody has been confirmed
- ☐ Patient has a Myasthenia Gravis Foundation of America (MGFA) clinical classification of II, III, or IV at initiation of therapy
- ☐ Patient's baseline MG-Activities of Daily Living (ADL) total score is ≥ 6 ***(Attach copy of assessment)***
- ☐ Patient has objective evidence of unresolved symptoms of gMG, e.g., difficulty swallowing, difficulty breathing, or functional disability

For Neuromyelitis Optica Spectrum Disorder (NMOSD):

- ☐ Presence of anti-aquaporin-4 (AQP4) antibody has been confirmed
- ☐ Patient has documented history of ≥ 2 acute attacks or relapses in the last 12 months prior to initiation of therapy
- ☐ Patient exhibits ONE of the following core clinical characteristics of NMOSD: ***(select all that apply)***
  - ☐ Optic neuritis
  - ☐ Acute myelitis
  - ☐ Area postrema syndrome (e.g., unexplained hiccups or nausea/vomiting)
  - ☐ Acute brainstem syndrome
  - ☐ Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
  - ☐ Symptomatic cerebral syndrome with NMOSD-typical brain lesions

LAB AND TEST RESULTS (required)

- ☐ LDL labwork (for PNH)
- ☐ Positive anti-AChR antibody lab (for gMG)
- ☐ Positive anti-aquaporin-4 (AQP4) antibody lab (for NMOSD)
- ☐ Other: _____

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

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