SOLIRIS (eculizumab)

☐ New Prescription/Referral
☐ Prescription Refill

# of Refills:

Rx: **Patient Name:** **DOB:**

SOLIRIS

*paroxysmal nocturnal hemoglobinuria (PNH)	*atypical hemolytic uremic syndrome (aHUS)
☐ 600mg IV infusion Qweek for the 1st 4 weeks, then	☐ 900mg IV infusion Qweek for the 1st 4 weeks, then
☐ 900mg IV infusion as a fifth dose 1 week later, then	☐ 1200mg IV infusion as a fifth dose 1 week later, then
☐ 900mg IV infusion Q 2weeks.	☐ 1200mg IV infusion Q 2weeks.

For other orders, please enter here:

Pre-Medication:

- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Others:
- ☐ Tylenol _____mg PO — ☐ 650mg ☐ 975mg
- ☐ Benadryl _____mg — ☐ 25mg ☐ 50mg — ☐ IV ☐ PO

ANA Kit Protocol:

- ☐ OK to use

Dx:

OTHERS (Dx + ICD Code 10):

N P I #:

Physician Signature **Date: (Valid for 1 year)**

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: **CLINIC:**

Contact Information: **Phone:** **Email:** **Fax:** **Other:**

Office Mailing Address:

Please include the following

- ☐ Patient demographics & Insurance attached
- ☐ Diagnosis (supporting)
- ☐ History and Physical
- ☐ Lab Results
- ☐ Clinical progress notes
- ☐ Medication List
- ☐ Other Test Results