InfuCare Rx

Soliris®
Referral Form

of Pages Faxed: ___________
Fax Referral To: 877-828-3941
Phone: 877-828-3940

Date Required: ______________________ Ship To: ☐ Home ☐ Office ☐ Other: ______________________

PATIENT INFORMATION

Patient Name: ______________________
Address: ______________________
City, State, Zip: ______________________
Home Phone: ______________________
Cell Phone: ______________________
Alternate Phone: ______________________
Date of Birth: ______________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________________
Fax: ______________________
DEA #: ______________ NPI #: ______________
Contact Person: ______________________

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: ______________________ ID: ______________ Group: ______________
Secondary Insurance: ______________________ ID: ______________ Group: ______________
Prescription Card: ______________ ID: ______________ BIN: ______________ PCN: ______________

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

☐ G70.0 Generalized Myasthenia Gravis (gMG)
☐ G36.0 Neuromyelitis Optica Spectrum Disorder (NMOSD)

☐ REMs Provider Enrollment Form Completed
☐ Documented meningococcal vaccine administration
Date Administered: ______________________
☐ Current Medication List: ______________________
☐ Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
☐ H&P
☐ Labs/Tests
☐ Patients Demographics, including insurance infomation
☐ Please attach original prescription orders

☐ Positive serologic test for anti-AChR antibody for gMG
☐ Positive serologic test for anti-AQP4 antibody for NMOSD

☐ MG-ADL Score: ______________________
☐ MGFA classification: ______________________

MEDICAL HISTORY

Has patient previously received IVIG? ☐ Yes ☐ No
Is patient currently undergoing TPE? ☐ Yes ☐ No
Patient Weight: ________ ☐ kg ☐ lbs Height: ________ ☐ cm ☐ in
Allergies: ______________________
Line Access: ☐ Peripheral ☐ PICC ☐ Port
Delivery Method: ☐ Infusion Pump ☐ Other: ______________
Therapy Start Date: ______________ Therapy End Date: ______________
Nursing Coordination:
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No
☐ Home health nursing coordination not necessary. Reason:
☐ MD office to administer to patient
☐ Home health nursing already coordinated

PRESCRIPTION INFORMATION

Soliris Prescription:	Quantity/Weeks Supply:	Refills:
☐ For Treatment of gMG & NMOSD:		
☐ Dose Titration – Month 1: Administer 900 mg via IV infusion every 7 days for 4 weeks	4-week	0
☐ Maintenance Dosing: Administer 1,200 mg via IV infusion every 2 weeks starting Week 5	☐ 4-week ☐ 12-week ☐ Other: ______	1-year supply
☐ Other: ______________________	☐ ______________	______

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol

☐ NaCl 0.9% 5mL
☐ NaCl 0.9% 10mL
☐ Heparin 10 units per mL
☐ Heparin 100 units per mL
☐ Other: ______________________

Premedications & Other Medications

☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Acetaminophen ________ mg PO prior to infusion
☐ Diphenhydramine ________ mg PO

ADDITIONAL COMMENTS:

Prescriber Signature: ______________________ **Date:** ______________

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