

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: Home Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Date of Birth: _____ Gender: _____
 Emergency Contact: _____ Phone: _____

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 information
 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: <input type="checkbox"/> Dose Titration – Month 1: Administer 900 mg via IV infusion every 7 days for 4 weeks	4-week	0
<input type="checkbox"/> Maintenance Dosing: Administer 1,200 mg via IV infusion every 2 weeks starting Week 5	<input type="checkbox"/> 4-week <input type="checkbox"/> 12-week <input type="checkbox"/> Other: _____	1-year supply
<input type="checkbox"/> Other: _____	<input type="checkbox"/> _____	_____

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
 NaCl 0.9% 5mL Heparin 10 units per mL
 NaCl 0.9% 10mL Heparin 100 units per mL Other: _____

Premedications & Other Medications
 Infusion supplies as per protocol Acetaminophen _____ mg PO prior to infusion
 Anaphylaxis Kit orders as per protocol Diphenhydramine _____ mg PO

ADDITIONAL COMMENTS:

Prescriber Signature: _____ **Date:** _____