InfuCare Rx®

Soliris®
Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940

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:		
☐ 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:** _____