

**INFUSION & MEDICAL CENTER**

**1. Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Patient Phone/Cell #** \_\_\_\_\_  
**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please select primary diagnosis and complete ICD10 Code):**  
 Primary Diagnosis: \_\_\_\_\_ Atypical Hemolytic Uremic Syndrome (aHUS) ICD-10 Code: D59.3 \_\_\_\_\_  
 \_\_\_\_\_ Myasthenia Gravis (MG) ICD-10 Code: G70. \_\_\_\_\_  
 \_\_\_\_\_ Neuromyelitis Optica Spectrum Disorders (NMOSD) ICD-10 Code: G36.0 \_\_\_\_\_  
 \_\_\_\_\_ Paroxysmal nocturnal hemoglobinuria (PNH) ICD-10 Code: D59.5 \_\_\_\_\_  
 \_\_\_\_\_ Other: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ (or attach list)

**3. Clinical Information – Please fax with Infusion Order Form:**  
 • Clinical MD Notes, labs, test supporting primary diagnosis  
 • Positive Serologic test results if appropriate for diagnosis (e.g. NMOSD or MG)  
 • Patient has had the appropriate meningococcal vaccines  Yes  No  
 • Prescriber is enrolled in Soliris REM Program  Yes  No

<b>Patient Weight:</b> _____ lbs.
<b>Patient Height:</b> _____ in.

**Lab Orders:** \_\_\_\_\_

**SOLIRIS® (eculizumab)** J Code: J1299

**4. Drug Order:**  
 **PNH** \_\_\_\_\_ # Refills (Recommend 15)  
 **Initial Dose** Infuse 600 mg IV weekly for 4 weeks, followed by 900 mg IV the following week and then 900 mg IV every 2 weeks thereafter  
 **Maintenance Dose** Infuse 900 mg IV every two weeks  
 **aHUS, gMG, NMOSD** \_\_\_\_\_ # Refills (Recommend 15)  
 **Initial Dose** Infuse 900 mg IV weekly for 4 weeks, followed by 1200 mg IV the following week and then 1200 mg IV every 2 weeks thereafter  
 **Maintenance Dose** Infuse 1200 mg IV every 2 weeks

**Pre-Medication Orders:** Acetaminophen 650 mg PO administered 30 min prior to infusion \*adjust to patient's needs  
 Other: \_\_\_\_\_

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.  
 By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

**5. Physician Signature:** \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_  
 Dispense as written Substitution permitted  
 Printed Physician's Name: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

<b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b>	<b>CENTRAL INTAKE PHONE</b> <b>803.999.1750</b>
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