Soliris Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ◯ G70.0 Myasthenia Gravis
- ◯ D59.5 Paroxysmal Nocturnal Hemoglobinuria
- ◯ D59.3 Atypical Hemolytic Uremic Syndrome
- ◯ Other _____

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

SOLIRIS ORDER

Soliris Dose:

◯ 600 mg weekly for the first 4 weeks, 900mg for the fifth dose one week later
900 mg every 2 weeks thereafter (PNH indication)

◯ 900 mg weekly for the first 4 weeks, 1200 mg for the fifth dose 1 week later
1200 mg every 2 weeks thereafter (aHUS indication)

Date of last Soliris Infusion: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____