SOLIRIS ENROLLMENT FORM

PATIENT INFORMATION

Patient Name: _____

Address: _____

Primary Phone:_____ □ Home □ Cell □ Work

DOB: _____ Gender: □ Male □ Female

Allergies: _____

E-mail : _____

Patient weight :_____lbs Primary Language:_____

PRESCRIBER INFORMATION

Prescriber's Name: _____

State License # : _____ NPI # : _____

DEA # _____

Address: _____

City, State, Zip:_____

Phone:_____ Fax: _____

Contact Person : _____ Phone : _____

INSURANCE INFORMATION

Please fax copy of demographics and insurance cards with this form, if available (front and back)

□ Clinical/Progress Notes, □ Test supporting primary diagnosis □ **Labs**: Required labs to be drawn by : □ Infusion Clinic □ Referring Physician

DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-10): □ D59.5 Paroxysmal Nocturnal Hemoglobinuria □ D59.3 Atypical Hemolytic Uremic Syndrome □ G36.0 Neuromyelitis Optica [Devic]

□ Other: _____

PRESCRIPTION INFORMATION

MEDICATION	DIRECTIONS	DURATION OF THERAPY
□ **SOLIRIS®**	□ **For Treatment of PNH:** □ Dose Titration— Month 1: Administer 600mg via IV infusion every 7 days for 4 weeks. □ 900 IV for the 5th dose 1 week later. □ Maintenance Dosing: Administer 900mg vial IV infusion every 2 weeks. □ Other:	□ 1-year supply Or □ Doses
	□ **For Treatment of aHUS– 18 years or older:** □ Dose Titration— Month 1: Administer 900mg via IV infusion every 7 days for 4 weeks. □ 1200 IV for the 5th dose 1 week later. □ Maintenance Dosing: Administer 1200mg vial IV infusion every 2 weeks. □ Other:	□ 1-year supply Or □ Doses
	□ **For Treatment of gMG and NMOSD:** □ 900mg weekly for the first 4 weeks, followed by □ 1200mg for the 5th dose 1 week later, then □ 1200mg every 2 weeks thereafter. □ Other:	□ 1-year supply Or □ Doses

□ ***Skilled nursing visit for self injection training and one additional visit with next dose if needed.***

Physician Signature X:_____ Date: _____

By Signing this prescription and using Southside pharmacy's services you authorize Southside Pharmacy to contact Insurance companies for prior authorization purposes on your behalf.

FAX TO (855) - 822 - 7838

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