

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
<input type="checkbox"/> SOLIRIS®	<input type="checkbox"/> For Treatment of PNH: <input type="checkbox"/> Dose Titration— Month 1: Administer 600mg via IV infusion every 7 days for 4 weeks. <input type="checkbox"/> 900 IV for the 5 th dose 1 week later. <input type="checkbox"/> Maintenance Dosing: Administer 900mg vial IV infusion every 2 weeks. <input type="checkbox"/> Other:	<input type="checkbox"/> 1-year supply Or <input type="checkbox"/> Doses
	<input type="checkbox"/> For Treatment of aHUS– 18 years or older: <input type="checkbox"/> Dose Titration— Month 1: Administer 900mg via IV infusion every 7 days for 4 weeks. <input type="checkbox"/> 1200 IV for the 5 th dose 1 week later. <input type="checkbox"/> Maintenance Dosing: Administer 1200mg vial IV infusion every 2 weeks. <input type="checkbox"/> Other:	<input type="checkbox"/> 1-year supply Or <input type="checkbox"/> Doses
	<input type="checkbox"/> For Treatment of gMG and NMOSD: <input type="checkbox"/> 900mg weekly for the first 4 weeks, followed by <input type="checkbox"/> 1200mg for the 5 th dose 1 week later, then <input type="checkbox"/> 1200mg every 2 weeks thereafter. <input type="checkbox"/> Other:	<input type="checkbox"/> 1-year supply Or <input type="checkbox"/> Doses

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

Physician Signature X: _____ Date: _____

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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.

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