

SOLIRIS REFERRAL FORM

Home Infusion

Alternate Site of Care

REP

TEL: 945-212-3707

NPI #: 1871219683

FAX: 866-790-3580

Patient Name _____ SSN (last 4): _____ DOB _____ Male Female

Street Address _____ Apt# _____ City _____ State _____ Zip _____

Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____

Ship to Patient at Home Physician Office Primary Language English Spanish Other _____

Allergies _____ PMH (attached) Current Medications (attached)

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT
_____	_____	_____	_____
PRESCRIBER NAME AND NPI#			
_____			# _____

Insured's Name _____ Relation to Patient _____

Insured's Phone Number _____ Prescription Card Yes No If Yes, Carrier _____

Policy/Group# _____ Bin# _____ Pcn# _____

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

- ICD-10 Code: **D59.5** Paroxysmal Nocturnal Hemoglobinuria
 D59.3 Atypical Hemolytic Uremic Syndrome
 G36.0 Neuromyelitis Optica
 G70.00 Myasthenia gravis without acute exacerbation
 G70.01 Myasthenia gravis with acute exacerbation
 Other ICD-10 _____ Description _____

PRESCRIPTION

PHYSICIAN ORDERS

- Transplant Related: Infuse Soliris _____mg IV x 1 initial dose, then _____mg IV QW starting day 8 for _____ doses, then _____mg IV Q14 days for _____doses or _____months.
- PNH, aHUS, Myasthenia Gravis, Neuromyelitis Optica Spectrum Disorder:
Infuse Soliris _____mg IV Q7 days for the first 4 weeks, followed by one single dose of _____mg 7 days after the 4th dose, and then _____mg IV Q14 days for _____doses or _____months.
- Dilute Soliris with NS or D5W to final concentration of 5mg/ml. Infuse over 35 minutes via gravity.
- Infusion needs to be completed in no longer than 2 hours.
- Other _____

PRE-MEDICATIONS

No pre-medication is recommended.

MENINGOCOCCAL VACCINE/ANTIBIOTIC ORDERS

Meningococcal Vaccine administered on _____ / _____ / _____.

Recommended to be given at least two weeks prior to first dose of Soliris, unless the risks of delaying Soliris therapy outweigh the risks of meningococcal infection. In those instances, it is recommended to place patient on antibiotic prophylaxis therapy to cover the 2 weeks post vaccination.

- Antibiotic Therapy Orders: _____ Duration: _____ days
- No Antibiotic Therapy

SUPPLY DETAILED WRITTEN ORDER (DWO) CONTAINING: ANAPHYLAXIS, MENINGOCOCCAL VACCINE/ANTIBIOTIC ORDERS, LAB WORK ORDERS, & NURSING ORDERS.

By signing this form and utilizing our services, you are authorizing VitalCare of South Dallas, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature _____ (Signature required. NO STAMPS) AND Hand write: brand medically necessary, if needed Date _____

Prescriber's Email _____ Prescriber's Fax _____

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