SOLIRIS REFERRAL FORM

☐ Home Infusion
☐ Alternate Site of Care

vitalcare of SOUTH DALLAS

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, Neromyelitis 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.

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

Prescriber's Email_____ **Prescriber's Fax** _____

Please visit **VITALCARE.COM/LOCATIONS/VITAL-CARE-OF-SOUTH-DALLAS/** for more information