

**NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.**

PATIENT INFORMATION			
Name:		DOB:	
Allergies:		Date of Referral:	
REFERRAL STATUS			
<input type="checkbox"/> New Referral		<input type="checkbox"/> Dose or Frequency Change	
<input type="checkbox"/> Order Renewal			
INFUSION OFFICE PREFERENCES (Optional)			
Preferred Location* <input type="checkbox"/> Mattoon		<input type="checkbox"/> Effingham	
<small>*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.</small>			
Diagnosis and ICD 10 CODE			
<input type="checkbox"/> Atypical Hemolytic Uremic Syndrome (aHUS)	ICD 10 Code: D59.3		
<input type="checkbox"/> Myasthenia Gravis, Aceptylcholine Receptor Antibody Positive	ICD 10 Code: G70.00		
<input type="checkbox"/> Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5		
<input type="checkbox"/> Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code: G36.0		
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)			
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis) <small>*Patient may be required to submit a pregnancy test prior to treatment</small>		<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis (must be within 1 year) <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> Aquaporin 4 Antibody Test Results (if NMO) <input type="checkbox"/> Documentation of meningococcal vaccines	
Is your patient enrolled in the Soliris-REMS program?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
List Tried & Failed Therapies (if Myasthenia Gravis):			
1)			
2)			
3)			
MEDICATION ORDERS			
<b>Dosing Wt for Calculations</b>		Ht:	BMI:
		Wt (in kg):	
<b>Dosing for aHUS, Myasthenia Gravis, and NMO</b>	<input type="checkbox"/> J1300 Soliris 900mg IV once weekly for 4 weeks, followed by 1200mg IV at week 5, then 1200 mg IV every 2 weeks thereafter		
	<input type="checkbox"/> J1300 Soliris _____ mg IV every _____		
<b>Dosing for PNH</b>	<input type="checkbox"/> J1300 Soliris 600mg IV once weekly for 4 weeks, followed by 900mg IV at week 5, then 900mg IV every 2 weeks thereafter		
	<input type="checkbox"/> J1300 Soliris _____ mg IV every _____		
<b>Duration</b>	<input type="checkbox"/> X 6 months	<input type="checkbox"/> X 1 year	<input type="checkbox"/> _____ doses
ADDITIONAL ORDERS / INFORMATION			
PRESCRIBER INFORMATION			
Prescriber name :			
Office Phone:		Office Fax:	Office Email:
Prescriber Signature:		Date:	Time:

**All information contained in this order form is strictly confidential and will become part of the patient's medical record.**

Contact us with questions at: SBL Infusion Center  
 Ph. 217-258-4150  
 217-342-7500  
 Fax Completed Form and all documentation to: Fax 217-342-7499