Sarah Bush Lincoln

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

PATIENT INFORMATION

Name: DOB:

Allergies: Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

Diagnosis	ICD 10 Code
☐ Atypical Hemolytic Uremic Syndrome (aHUS)	ICD 10 Code: D59.3
☐ Myasthenia Gravis, Aceytlcholine Receptor Antibody Positive	ICD 10 Code: G70.00
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5
☐ Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code: G36.0

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

- ☐ This signed order form by the provider
- ☐ Patient demographics AND insurance information
- ☐ Acetylcholine Receptor Antibody Test Results (if Myasthenia Gravis)

*Patient may be required to submit a pregnancy test prior to treatment

- ☐ Clinical/Progress notes supporting primary diagnosis (must be within 1 year)
- ☐ Labs and Tests supporting primary diagnosis
- ☐ Aquaporin 4 Antibody Test Results (if NMO)
- ☐ Documentation of meningococcal vaccines

Is your patient enrolled in the Soliris-REMS program? ☐ Yes ☐ No

List Tried & Failed Therapies (if Myasthenia Gravis):

1)

2)

3)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Dosing for aHUS, Myasthenia Gravis, and NMO	☐ J1300 Soliris 900mg IV once weekly for 4 weeks, followed by 1200mg IV at week 5, then 1200 mg IV every 2 weeks thereafter ☐ J1300 Soliris _________ mg IV every _________
Dosing for PNH	☐ J1300 Soliris 600mg IV once weekly for 4 weeks, followed by 900mg IV at week 5, then 900mg IV every 2 weeks thereafter ☐ J1300 Soliris _________ mg IV every _________

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _________ **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:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401