



1

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Allergies: _____ Ht (in): _____ Wt (kg): _____ Gender: M | F

Demographic Information Attached: Yes

Insurance Information Attached (front and back of card): Yes

Infusion location: Beachwood Painesville

Patient Status: New to Therapy

Fairlawn Westlake

Order Renewal

Middleburg Heights Youngstown

Change of Dose | Frequency

Continuing Treatment | Transfer from a Prior Site of Care. Next Treatment Due Date: _____

(Efforts will be taken to maintain treatment schedule, but next due date cannot be guaranteed)

2

CLINICAL INFORMATION

ICD-10 Code (required & as specific as possible): _____ ICD-10 Description: _____

Clinical/Progress Notes, Labs, Tests Supporting Primary Diagnosis Attached: Yes

Date of Meningococcal Vaccination: _____

NPI of Prescribing Physicians (for Solaris REMS program): _____

3

INFUSION ORDER

Soliris: 600 mg IV weekly for the first 4 weeks, followed by 900 mg IV for the fifth dose 1 week later, than 900 mg IV every 2 weeks thereafter

Maintenance Dose: 900 MG IV every 2 weeks

900 mg IV weekly for the first 4 weeks, followed by 1200 mg IV for the fifth dose 1 week later, than 1200 mg IV every 2 weeks thereafter

Maintenance Dose: 1200 MG IV every 2 weeks

Pre-Medication Order:

Acetaminophen 650 mg PO

Benadryl 25 mg IVP or PO (circle preference)

Solu Medrol 125 mg IVP

Comments/Special Considerations: _____

LAB REQUIREMENTS & LAB MONITORING ARE THE RESPONSIBILITY OF THE PRESCRIBER. INFUSION ORDERS ARE VALID FOR ONE YEAR (UNLESS OTHERWISE SPECIFIED).

INFUSIONS WILL BE ADMINISTERED PER ID CONSULTANTS INFUSION CENTER POLICY AND PROTOCOLS.

4

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

Practice Name: _____ Fax: _____

Office Contact: _____ Email: _____

Prescriber Signature: _____ Date: _____