AYSA
THERAPEUTICS INFUSION

SOLIRIS (ECULIZUMAB) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ______________________ DOB: ______________ Phone: ______________________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis:
- ☐ Paroxysmal nocturnal hemoglobinuria (PNH) ICD-10 Code: __________
- ☐ Atypical hemolytic uremic syndrome (aHUS) ICD-10 Code: __________
- ☐ Myasthenia Gravis (gMG) with AChR antibody positive ICD-10 Code: __________
  gMG Classification: ☐ II ☐ III ☐ IV
- ☐ Neuromyelitis Optica Spectrum disorders (NMOSD) ICD-10 Code: __________

Patient Weight: __________ lbs. Allergies: ______________________________

- ☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis and including past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy.
- ☐ Positive serologic test for anti-aquaporin antibodies (if NMOSD diagnosis)
- ☐ Positive serologic test for anti-AChR antibodies (if Myasthenia Gravis diagnosis)

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ____

SOLIRIS ORDERS

Adult Dosing:

☐ PNH (Initial Dose)
600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every 2 weeks thereafter
- ☐ Maintenance Dose: 900mg IV every 2 weeks

☐ aHUS, gMG, and NMOSD (Initial Dose)
900mg IV weekly for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter
- ☐ Maintenance Dose: 1200mg IV every 2 weeks

Required:
- ☐ Yes ☐ No - Patient has had the meningococcal vaccines (both MenACWY and MenB)
- ☐ Yes ☐ No - Prescriber is enrolled in Soliris REMS Program

Optional: Patient may enroll in One Source by calling (888) 765-4747

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ____________________ Physician Name: ____________________ Date: __________
Phone: __________________ Fax: __________________ Contact Person: ______________________

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