InfuseAble Care
INFUSION SUITES & IMMEDIATE CARE SERVICES

Patient Name
DOB
Address
Cell Phone

SOLIRIS (eculizumab)

Status	☐ New Therapy ☐ Order Renewal ☐ Dosage or Frequency Change
Diagnosis	☐ ICD 10 Code: G70.00 Anti-AchR+ Generalized Myasthenia Gravis (gMG) ☐ ICD 10 Code: D59.3 Atypical Hemolytic Uremic Syndrome (aHUS) ☐ ICD 10 Code: D59.5 Paraxysmal Nocturnal Hemoglobinuria (PNH) ☐ ICD 10 Code: ______ Other: ________________________
Pertinent Medical Hx	Meningitis Vaccine status & date: _______________ - ***OR*** - ☐ Give MenACWY vaccine x 2 doses, separated by 8 weeks. ☐ Vaccines must be given 2 weeks prior to starting Soliris infusion ☐ Vaccines may be given same day as starting Soliris infusion
REMS	Is referring physician enrolled in FDA REMS program? ☐ Y ☐ N
Labs	Labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician If Infusion Clinic: __________________________
Premeds	☐ No premeds necessary ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO ☐ cetirizine (Zyrtec) 10mg PO - ***OR*** - ☐ diphenhydramine (Benadryl) 25mg PO ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV ☐ other: ___________
IV Fluids	☐ NS TKO ☐ Other: ____________
Medication Order	**Generalized Myasthenia Gravis (gMG)** – *or* – **Atypical Hemolytic Uremic Syndrome (aHUS)** ☐ Induction: Soliris 900mg IV every week x 4 doses, then maintenance starting at Week 5. ☐ Maintenance: Soliris 1200mg IV every 2 weeks. **Paroxysmal Nocturnal Hemoglobinuria (PNH)** ☐ Induction: Soliris 600mg IV every week x 4 doses, then maintenance starting at Week 5. ☐ Maintenance: Soliris 900mg IV every 2 weeks. Refills: ☐ x 1 year ☐ x ______doses ☐ No refills; give this dose only.
Monitoring	Monitor for signs/symptoms of hypersensitivity during infusion and 60 mins post-infusion. For any signs of infusion reaction: STOP infusion. Contact on-site provider for instruction.
Additional Orders	
Physician Information	Physician Name ______________________ NPI _____________ Office Contact ______________________ Phone _____________ **Provider Signature:** ______________________ Date _____________

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REQUIRED DOCUMENTATION

o Patient Demographics & **Insurance** Information:	− Copy of patient's insurance card – front and back	FAX to (480) 400-6121 Intake Specialist (480) 927-3800 **referral@infuseablecare.com**
o **Clinical / Progress Notes**, supporting primary diagnosis:	− 2 most recent office notes − Medication history	
o Most Recent **Labs**:	− Meningococcal vaccination history − Acetylcholine Receptor Antibody Test (if gMG)	