SOLIRIS INFUSION ORDER (ECULIZUMAB)

INFUSIONMED | USA
LIVING YOUR BEST LIFE. ONE DROP AT A TIME.

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

Antibody Test Results: _____

Labs to be drawn by: O Infusion Clinic O Referring Physician

Lab Orders: _____

SOLIRIS (ECULIZUMAB) ORDERS

O Dosage for aHUS, Myasthenia Gravis, and NMOSD
900 mg once weekly for 4 weeks, 1200 mg on week 5, then 1200 mg every 2 weeks

O Dosage for PNH
600 mg once weekly for 4 weeks, 900 mg on week 5, then 900 mg every 2 weeks thereafter

O Other _____mg every _____

****PATIENT MUST BE ENROLLED AND AUTHORIZED IN THE SOLIRIS-REMS PROGRAM**

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994