VEROS HEALTH
Excellence in Complex Care

Soliris® Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

Referral Process

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Name:	Physician's name:
Address:	License #: NPI #:
City: State: Zip:	DEA #:
Home Phone: Other Phone:	Address:
Email:	City: State: Zip:
DOB: Social Security #:	Office Contact:
Gender: ☐ M ☐ F Height: Weight:	Phone: Fax:

3. DIAGNOSIS Year of diagnosis: _____

☐ Myasthenia Gravis w/o acute exac. (G70.00)
☐ Myasthenia Gravis with acute exac. (G70.01)
ACHR-AB results (required) _____
MGFA Classification _____
MG-ADL Scores _____

☐ Neuromyelitis Optica (G36.0)
AQP4 Autoantibodies test (required) _____
MRI _____
CSF test _____

4. INSURANCE INFORMATION
Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. ADDITIONAL INFORMATION REQUESTED
Please provide relevant history, including office and hospitalization notes

Allergies: _____

Patient has received meningococcal vaccine ☐ Yes ☐ No Date Received _____

Previous tried and failed meds (immune suppressants, IVIG, plasma exchange): _____

PRESCRIPTION INFORMATION Anticipated Start Date: _____

Soliris® (eculizumab)
- 900 mg weekly for the first 4 weeks, followed by
- 1200 mg for the fifth dose 1 week later, then
- 1200 mg every 2 weeks thereafter

6. FLUSH ORDERS
PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml
Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

ANAPHYLAXIS ORDERS
Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

Skilled Nursing Services Needed? ☐ Yes ☐ No Additional Instructions: _____

Dispense quantity: _____ Refills: _____

6. ☐ Dispense as written ☐ Substitution Permitted

PHYSICIAN'S SIGNATURE (required): _____ **Date:** _____

Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.