

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ G70.00 Myasthenia gravis without (acute) exacerbation (gMG)

☐ G70.01 Myasthenia gravis with (acute) exacerbation (gMG)

☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS)

☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH)

☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO

☐ Cetirizine (Zyrtec) 10mgPO

☐ Loratadine (Claritin) 10mgPO

☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV

☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Meningococcal Vaccination,
Clinicals to support that they have one or more of the
following: PNH, aHUS, gMG, NMOSD

☐ Other: _____

Soliris® (eculizumab) Administration (Select one):

aHUS, Myasthenia Gravis , and NMO

☐ Soliris 900mg IV once weekly for 4 weeks, followed by 1200mg IV at week 5, then 1200mg IV every 2 weeks thereafter

☐ Soliris _____ mg IV every _____ ☐ Other _____

PNH

☐ Soliris 600mg IV once weekly for 4 weeks, followed by 900mg IV at week 5, then 900mg IV every 2 weeks thereafter

☐ Soliris _____ mg IV every _____ ☐ Other _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ Refills: ☐ zero ☐ 6 months ☐ 12 months ☐ _____ (Prescription valid for one year, unless otherwise indicated)

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date