

SOLIRIS (EXULIZUMAB) INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis and including past tried and/or failed therapies intolerance, outcomes or contraindications to conventional therapy
- ☐ Positive serologic test for anti-AChR antibodies (if Myasthenia Gravis diagnosis)

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- ☐ Paroxysmal nocturnal hemoglobinuria (PNH) (ICD-10: _____)
- ☐ Atypical hemolytic uremic syndrome (aHUS) (ICD-10: _____)
- ☐ Myasthenia Gravis (gMG) with AChR antibody positive (ICD-10: _____)

J Code: J1300

SOLIRIS ORDERS

Adult Dosing:

Pt. Weight _____ kg

- ☐ PNH
600mg IV weekly for first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every 2 weeks thereafter
- ☐ aHUS and gMG
900mg IV weekly for first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter

Required:

- ☐ Yes ☐ No - Patient has had the meningococcal vaccine
- ☐ Yes ☐ No - Patient is enrolled in Soliris REMS program

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	