TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

SOLIRIS ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Soliris

For adult patients with aHUS, gMG, NMOSD:

☐ Initiation: Infuse 900mg IV over 35 minutes weekly x 4 weeks, then 1200mg IV at week 5.

☐ Maintenance: Infuse1200mg IV over 35 minutes every 2 weeks.

For adult patients with PNH:

☐ Infuse 600mg IV over 35 minutes weekly x 4 weeks, then 900mg IV at week 5.

☐ Maintenance: Infuse 900mg IV over 35 minutes every 2 weeks.

Refills x one year from date of signature unless indicated below.

☐ _____ Refills

Please include the following vaccine dates required for infusion. First dose of vaccine should be giventwo weeks prior to start of therapy. Continued monitoring of vaccine administration and scheduling will be the responsibility of prescriber:

✓ MenACWY and MenB vaccine administration dates

PRE-MEDICATIONS

Oral

☐ Acetaminophen: _____325mg _____500mg _____650mg
☐ Loratadine: 10mg
☐ Cetirizine: 10mg
☐ Diphenhydramine: _____25mg _____50mg
☐ Famotidine: _____20mg _____40mg
☐ Ibuprofen: _____ 200mg _____400mg_____600mg
☐ Ondansetron: _____4mg _____ 8mg
☐ Other: _____

IV

☐ Dexamethasone: _____4mg _____8mg
☐ Diphenhydramine: _____25mg_____50mg
☐ Famotidine: _____20mg_____40mg
☐ Methylprednisolone: 125mg
☐ Hydrocortisone: 100mg
☐ Ondansetron: _____4mg _____8mg
☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

Substitution Allowed: