

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: _____	Therapy Status <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Patient Name: _____	Allergies: _____	
Date of Birth: _____	Weight: _____ lbs OR _____ kg	

PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Soliris	For adult patients with aHUS, gMG, NMOSD: <input type="checkbox"/> Initiation: Infuse 900mg IV over 35 minutes weekly x 4 weeks, then 1200mg IV at week 5. <input type="checkbox"/> Maintenance: Infuse 1200mg IV over 35 minutes every 2 weeks.	Refills x one year from date of signature unless indicated below. <input type="checkbox"/> _____ Refills	<p><i>Please include the following vaccine dates required for infusion. Primary vaccine series should be completed two weeks prior to start of therapy. Continued monitoring of booster vaccine administration and scheduling will be the responsibility of the prescriber:</i></p> <p>✓ MenACWY and MenB vaccine administration dates</p>
	For adult patients with PNH: <input type="checkbox"/> Infuse 600mg IV over 35 minutes weekly x 4 weeks, then 900mg IV at week 5. <input type="checkbox"/> Maintenance: Infuse 900mg IV over 35 minutes every 2 weeks.		

PRE-MEDICATIONS

<p>Oral</p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p>IV</p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> 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) <ul style="list-style-type: none"> • 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: _____ Prescriber Name	Substitution Allowed: _____ Prescriber Name
_____ Date	_____ Date