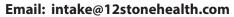
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





SOLIRIS ORDER FORM							
Date: ICD-10 Coo		ICD-10 Code:	Code:		Therapy Status		
Patient Name:		Allergies:			☐ New Start		
Date of Birth:		Weight:Ibs OR		kg	☐ Continuing 1	Fherapy: Last Dose:	
PROVIDER INFORMATION							
Ordering Provider:				Provider Fax:			
Provider NPI:			_ Pı	Provider Address:			
Provider Phone:							
MEDICATION ORDER							
	For adult patients with aHUS, gMG, NMOSD:					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	
	☐ Initiation: Infuse 900mg IV over 35 minutes weekly x 4 weeks, then 1200mg IV at week 5.		,		one year from nature unless ed below. Refills		
	☐ Maintenance: Infuse1200mg IV over 35 minutes every 2 weeks.		very	Refills for o			
Soliris	For adult patients with PNH:			indicate		responsibility of the prescriber:	
	☐ Infuse 600mg IV over 35 minutes weekly x 4 weeks, then 900mg IV at week 5.		(S,			✓ MenACWY and MenB vaccine administration dates	
	☐ Maintenance: Infuse 9 2 weeks.	00mg IV over 35 minutes e	very	,			
PRE-MEDICATIONS							
<u>Oral</u> <u>IV</u>							
□ Acetaminophen:325mg500mg650mg				□ Dexamethasone:4mg8mg			
□ Loratadine: 10mg				☐ Diphenhydramine:25mg50mg			
☐ Cetirizine: 10mg				☐ Famotidine:20mg40mg			
□ Diphenhydramine:25mg50mg				☐ Methylprednisolone: 125mg ☐ Hydrocortisone: 100mg			
□ Famotidine:20mg40mg □ Ibuprofen: 200mg400mg600mg				☐ Ondansetron:4mg8mg			
				Other:			
☐ Ondansetron:4mg 8mg ☐ Other:							
LAB ORDERS (please indicate any labs to be drawn and frequency)			v)	OTHER REQUIRED DOCUMENTATION			
				(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			
Surveillance lab ordering and monitoring is the responsibility of the prescriber				Medication List Recent Lab Work			
By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW) By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.							
Dispense as Written:			:	Substitution Allowed:			
Prescriber Signature		Date	_	Prescriber Signature		Date	