Soliris (eculizumab)

Provider Order Form rev. 5/20/2022

www.aleracare.com
ph: 888-209-8874 fax: 833-329-4738

PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)

D58.9 Hereditary hemolytic anemia, unspecified

G70.00 Myasthenia Gravis

G36.0 Neuromyelitis optica spectrum disorder (NMOSD)

Other: ______________________________

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg / PO IV IV

methylprednisolone (Solu-Medrol) 40mgIV 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: ____

Dose: _________ Route: _____ Frequency: ________________________

MEDICATION ORDER

Soliris (eculizumab)

Initiation therapy:

600mg IV weekly for the first 4 weeks, followed by 900 mg IV for the fifth dose 1 week later, then 900mg IV every 2 weeks thereafter

900mg IV weekly for the first 4 weeks, followed by 1200 mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter

Other: ____

Maintenance therapy:

900mg IV every 2 weeks

1200mg IV every 2 weeks

Other____

Order Expiration Date (mm/dd/yy): ___________________
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

Check here if this is a stat order