

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:

(ICD-10: _____)

(ICD-10: _____)

(ICD-10: _____)

Diagnosis:

□ Paroxysmal nocturnal hemoglobinuria (PNH)

□ Atypical hemolytic uremic syndrome (aHUS)

□ Myasthenia Gracis (gMG) with AchR antibody positive

J Code: J1300

[SOLIRIS ORDERS]	
Adult Dosing:		Pt. Weight	kg
 PNH 600mg IV weekly for first 4 weeks, followed 2 weeks thereafter 	by 900mg IV for the fifth dose 1	1 week later, then 900mg IV every	
□ aHUS and gMG 900mg IV weekly for first 4 weeks, followed every 2 weeks thereafter	by 1200mg IV for the fifth dose	1 week later, then 1200mg IV	
Required:			
□Yes □No - Patient has had the meningoco	ccal vaccine		
□ Yes □ No - Patient is enrolled in Soliris RE	MS program		

Additional Instructions:

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