SOLIRIS (ECULIZUMAB)
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis:
- ☐ Paroxysmal nocturnal hemoglobinuria (PNH) (ICD-10 Code: D59.5)
- ☐ Atypical hemolytic uremic syndrome (aHUS) (ICD-10 Code: D59.3)
- ☐ Myasthenia Gravis (gMG) w/out acute exacerbation (ICD-10 Code: G70.00) gMG Classification: ☐ II ☐ III ☐ IV
- ☐ Neuromyelitis Optica Spectrum disorders (NMOSD) (ICD-10 Code: G36.0)
- ☐ Other _____ **ICD-10 Code:** _____

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Soliris Adult Dosing:

PNH Diagnosis

☐ Initial start: 600 mg IV weekly for the first 4 weeks, followed by 900 mg IV for the 5th dose 1 week later, then 900 mg IV every 2 weeks thereafter x1 year

☐ Maintenance dose: 900 mg IV every 2 weeks x1 year

aHUS, gMG, and NMOSD diagnosis:

☐ Initial start: 900 mg IV weekly for the first 4 weeks, followed by 1200 mg IV for the 5th dose 1 week later, then 1200 mg IV every 2 weeks thereafter x1 year

☐ Maintenance dose: 1200 mg IV every 2 weeks x1 year

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Hy-Vee Health ☐ Referring Provider

Other Orders: _____

Anaphylactic Reaction Orders:
- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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Hy-Vee health

COMPREHENSIVE SUPPORT FOR SOLIRIS (ECULIZUMAB) THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Prescriber enrolled in REMS
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis, including past tried and failed therapies, intolerance, outcomes or contraindications to conventional therapy
  - ☐ MG-ADL score (gMG diagnosis): _____
  - ☐ Previous or current therapies: _____
  - ☐ aHUS – The following have been ruled out in patients with aHUS:
    - ☐ Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS)
      - ☐ Yes ☐ No
    - ☐ Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency)
      - ☐ Yes ☐ No
- ☐ Labs attached
  - ☐ AchR antibody (gMG diagnosis)
  - ☐ AQP4 antibody (NMOSD diagnosis)
  - ☐ CBC and CMP (aHUS diagnosis)
- ☐ Diagnostic testing to support diagnosis
  - ☐ Flow Cytometry test (PNH diagnosis)
  - ☐ Abnormal Neuromuscular Transmission test (i.e., SFEMG) (MG diagnosis)
  - ☐ CBC and CMP (aHUS and PNH diagnosis)
- ☐ Is the patient enrolled in OneSource?
  - ☐ Yes ☐ No

  Patient may enroll in One Source by calling 888.765.4747
- ☐ Other medical necessity: _____

Required Prescreening

Has the patient had both meningococcal vaccines (MenACWY and Men B)?

☐ **Yes** ☐ **No**

☐ **Attach proof of meningococcal vaccines – both vaccines are required prior to therapy**

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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