BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

SOLIRIS (ECULIZUMAB)
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

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

☐ Maintenance Dose: 900mg IV every 2 weeks x 1 year

aHUS, gMG, and NMOSD Diagnosis-

☐ Initial Start: 900mg IV weekly for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter x 1 year

☐ Maintenance Dose: 1200mg IV every 2 weeks x 1 year

Lab orders: _____ **Frequency:** _____

Required labs to be drawn by: ☐ Biocare Infusion ☐ Referring Provider

Other orders: _____

Anaphylactic Reaction Orders:

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

Flush orders: NS 1-20mL 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 *Biocare Infusion,* 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 Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
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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 tired 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 1-888-765-4747
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

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**

Biocare Infusion 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.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance