

Provider Order Form
SOLIRIS (ECULIZUMAB BIOSIMILARS)



PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

Patient Demographics Insurance card Progress Notes supporting DX Meningococcal vaccination

PATIENT

Full Name: _____ DOB: _____
Mobile Phone: _____ Height: _____ Weight: lbs kg
Allergies: _____ NKDA
Patient status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

Generalized Myasthenia Gravis (gMG) G70. Paroxysmal Nocturnal Hemoglobinuria (PNH) D59.5
 Neuromyelitis Optica Spectrum Disorder (NMOSD) G36.0 Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____
Practice Name: _____ Referral Coordinator Name: _____
Practice Address: _____
Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

Acetaminophen (Tylenol) PO 500 mg 650 mg 1000 mg
 Diphenhydramine (Benadryl) PO IV 25 mg 50 mg
 Methylprednisolone (Solu-Medrol) IV 40 mg 125 mg
 Cetirizine (Zyrtec) 10 mg PO
 Other: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
<input type="checkbox"/> Soliris (Eculizumab), IV	<input type="checkbox"/> 600 mg	<input type="checkbox"/> Induction: 600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every weeks thereafter
<input type="checkbox"/> Eculizumab Biosimilar, IV: <input type="checkbox"/> Bkemv <input type="checkbox"/> Epysqli	<input type="checkbox"/> 900 mg	<input type="checkbox"/> Maintenance: 900 mg every 4 weeks
<input type="checkbox"/> Soliris (Eculizumab), IV	<input type="checkbox"/> 900 mg	<input type="checkbox"/> Induction: 900mg IV weekly for the for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every weeks thereafter
<input type="checkbox"/> Eculizumab Biosimilar, IV: <input type="checkbox"/> Bkemv <input type="checkbox"/> Epysqli	<input type="checkbox"/> 1200 mg	<input type="checkbox"/> Maintenance: 1200mg IV every 2 weeks

Refills Zero 12 months _____ Order valid for 1 year unless otherwise stated. _____
 Flush with 0.9% sodium chloride at infusion completion.
 Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
 Other _____ at each dose every _____

SPECIAL INSTRUCTIONS

Provider Signature _____ Date _____