vitalcare of LITTLE ROCK
Fountains Infusion Center
15200 Chenal Pkwy. Suite 300 Little Rock AR
Phone: 501-451-6080 Fax:501-451-6081

# 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:** |

**Diagnosis:**

☐ Paroxysmal nocturnal hemoglobinuria (PNH) (ICD-10: _____)

☐ Atypical hemolytic uremic syndrome (aHUS) (ICD-10: _____)

☐ Myasthenia Gracis (gMG) with AchR antibody positive (ICD-10: _____)

**J Code: J1300**

## SOLIRIS ORDERS

Pt. Weight _____ kg

**Adult Dosing:**

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

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

**Required:**

☐ Yes ☐ No - Patient has had meningococcal vaccines (MenACWY and MenB). If yes, when_____

☐ Yes ☐ No - Patient is enrolled in Soliris REMS program

**Additional Instructions:**

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