SOLIRIS (ECULIZUMAB) INFUSION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:	ZIP:	
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Soliris (eculizumab)	□ 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 □ 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 □ 900mg IV every 2 weeks □ 1200mg IV every 2 weeks □ Other: _____	□ x 1 year □ _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____

Required labs to be drawn by: □ LIVbetter □ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* 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.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR SOLIRIS (ECULIZUMAB) THERAPY

PATIENT INFORMATION

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 (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