



**SOLIRIS® ORDER FORM**

(\* - Required Fields)

New Referral     Order Renewal     Medication/Order Change  
 Benefits Verification Only     Discontinuation Order

**PATIENT INFORMATION**

NAME*:	DOB*:	SEX:    M    F
ADDRESS:	PHONE:	
WEIGHT:          LBS    KG    HEIGHT:	EMAIL:	
ALLERGIES:		

**PHYSICIAN INFORMATION**

PHYSICIAN NAME*:	PRACTICE NAME:
ADDRESS:	OFFICE CONTACT*:
PHONE:          FAX:	EMAIL (FOR UPDATES):

**SOLIRIS ORDER\*:** \_\_\_\_\_      ICD-10\*: \_\_\_\_\_  
 (SELECT ONE OF THE FOLLOWING)

**Initial/Reload Dosing and Maintenance Dosing:** \_\_\_\_\_ mg IV for the first 4 weeks,  
 followed by \_\_\_\_\_ mg for the fifth dose 1 week later, then \_\_\_\_\_ mg every 2 weeks thereafter  
**OR**  
 Maintenance Dosing: \_\_\_\_\_ mg/kg IV every \_\_\_\_\_ weeks

Physician Signature\* \_\_\_\_\_      Date\* (Order is Valid for One Year) \_\_\_\_\_  
*Infusion will be administered per MPP policy and protocols*

**REQUIRED DIAGNOSIS:**

Myasthenia Gravis (gMG)  
 Paroxysmal Nocturnal Hemoglobinuria  
 Atypical Hemolytic Uremic Syndrome  
 Other \_\_\_\_\_

**REQUIRED DOCUMENTATION CHECKLIST:**

Patient Demographics  
 Insurance Card/Information  
 Clinical/Progress Notes supporting DX  
 Current Medication List and H&P  
 Positive AchR (gMG)  
 MG-ADL Score \_\_\_\_\_  
 MGFA classification: \_\_\_\_\_  
 Did patient receive Meningococcal Vaccine?  
                          Yes     No

Last Infusion/Injection Date: \_\_\_\_\_

**STANDING LAB ORDERS:**     CMP     CBC     CRP     ESRP     HFR     UA

Labs to be drawn by Infusion Center      Frequency \_\_\_\_\_

**NOTES/ADDITIONAL COMMENTS:**

**Locations:**

-----Colorado-----

Lakewood

-----Florida-----

Fort Myers Coming Soon  
 Jacksonville  
 Kissimmee Coming Soon  
 Port St. Lucie Coming Soon  
 Winter Park Coming Soon

-----Texas-----

Arlington  
 Dallas  
 Denton  
 Duncanville  
 Ft. Worth Coming Soon  
 Irving  
 Rockwall Coming Soon  
 Southlake  
 Lewisville  
 Plano  
 Tyler