MPP Infusion Centers

A Multispecialty Physician Partner Company

Fax To: (855) 891-2191
Email To: MPPReferral@mppinfusion.com
Have a Question? Call: (855) 478-1528

SOLIRIS® ORDER FORM

REFERRAL STATUS

☐ New Referral ☐ Order Renewal ☐ Restart ☐ Medication/Order Change ☐ Benefits Verification Only
☐ D/C Infusion *(Medication(s) to D/C _____)*

LOCATION

☐ Denver ☐ Arlington ☐ Dallas ☐ Duncanville ☐ Irving ☐ Lewisville ☐ Plano ☐ Southlake
☐ Tyler

PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: ☐ MALE ☐ FEMALE
ADDRESS:	PHONE #:	
WEIGHT: ☐ LBS ☐ KG HEIGHT:	EMAIL:	
ALLERGIES:		

Please check that the following are included

☐ Patient demographics and insurance attached	☐ Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached	
☐ Current Medication List	☐ Positive AchR (gMG)	Did patient receive Meningococcal Vaccine? ☐ Yes ☐ No
☐ MG-ADL Score_____	MGFA classification:_____	

PHYSICIAN INFORMATION

Physician Name:	Email *(if you would like referral updates)*:
Practice Name:	Phone Number:
Office Contact:	Fax Number:

DIAGNOSIS

☐ Myasthenia Gravis (gMG)	☐ Paroxysmal Nocturnal Hemoglobinuria	☐ Atypical Hemolytic Uremic Syndrome
☐ Other:		

ICD-10 CODE: **Date of last infusion/injection:**

MEDICATION ORDERS

SOLIRIS ORDERS:

☐ Initial/Reloading Dose: _____mg IV for the first 4 weeks, followed by ____ mg for the fifth dose 1 week later, then _____mg every 2 weeks thereafter

☐ Maintenance Dose: _____mg IV every ____ weeks

Notes/Comments

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

STANDING LAB ORDERS

☐ Labs to be Drawn by Infusion Center Frequency: _____ Every Infusion ☐ Other (*please specify*) _____

☐ CMP ☐ CBC ☐ CRP ☐ ESRP ☐ HFR ☐ UA