Please fax both pages of completed form to your team at 833.951.1686.

To reach your team, call toll-free 800.442.5781.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Soliris® (eculizumab)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: ☐ Male ☐ Female Pronouns _____ Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): ☐ **D59.5 Paroxysmal nocturnal hemoglobinuria** ☐ **D59.3 Hemolytic-uremic syndrome** ☐ **D59.32 Hereditary hemolytic-uremic syndrome** ☐ **D59.39 Other hemolytic uremic syndrome** ☐ **G70.00 Myasthenia Gravis without (acute) exacerbation** ☐ **G70.01 Myasthenia Gravis with (acute) exacerbation** ☐ **G36.0 Neuromyelitis optica** ☐ **D58.8 Other specified hereditary hemolytic anemias** ☐ **D59.4 Other non-autoimmune hemolytic anemias (including microangiopathic hemolytic anemia)**

☐ **D59.8 Other acquired hemolytic anemias** ☐ **Other** _____

MG-ADL* score (if known) _____ Weight _____ kg/lbs Height _____ cm/in Date recorded _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Adverse reactions with previous Soliris treatments? _____

Has the patient received Meningitis vaccination? ☐ Yes ☐ No Date of vaccination _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions
Soliris® (eculizumab)	300mg/30mL vial	**Loading dose:** _____ mg IV every _____ weeks for _____ weeks. **Maintenance dose:** _____ mg IV every _____ weeks. **Infusion method:** ☐ Gravity ☐ Pump ☐ Other directions, please list here: _____

Dilution and infusion rate

Loading dose:
Dilute Soliris with selected diluent as directed per manufacturer guidelines to a final concentration of 5mg/mL.
☐ If different: list here _____
If adult patient:
Infusion rate: As directed per manufacturer guidelines _____
☐ If different, list here _____.
If pediatric patient:
Infusion rate: As directed per manufacturer guidelines _____
☐ If different, list here _____.

Maintenance dose:
Dilute Soliris with selected diluent as directed per manufacturer guidelines to a final concentration of 5mg/mL.
☐ If different: list here _____
If adult patient:
Infusion rate: As directed per manufacturer guidelines _____
☐ If different, list here _____.
If pediatric patient:
Infusion rate: As directed per manufacturer guidelines _____
☐ If different, list here _____.

Check one (0.9% Sodium Chloride will be used if no box is checked):
☐ 0.9% Sodium Chloride Injection ☐ 0.45% Sodium Chloride Injection ☐ 5% Dextrose in Water Injection ☐ Ringer's Injection

☐ Other instructions _____

Complete the below section if assistance from Accredo is requested in the coordination of your patient's infusion therapy

Is Accredo home nursing service requested? ☐ Yes ☐ No Vascular access: ☐ Peripheral ☐ Central ☐ Port

Supplies: (please strike through if not required)
Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.
PERIPHERAL Access: 0.9% Normal Saline 3mL intravenous before and after infusion, or as needed for line patency.
☐ If different, please list here _____
PORT/CENTRAL Access: 0.9% Normal Saline 5mL intravenous before and after infusion, or as needed for line patency.
Heparin 10 units per mL 5mL intravenous as needed for final flush.
☐ If different, please list here _____

Is your patient new to therapy? ☐ Yes ☐ No

Hypersensitivity/Anaphylaxis Stop infusion
Medicate with: Epinephrine 0.3mg Auto Injector – Stop infusion and inject dose per packaging for hypersensitivity/anaphylaxis (patient weighs greater than or equal to 30kg) **OR** Epinephrine JR 0.15mg/0.3mL Auto injector – Stop infusion and inject dose per packaging for hypersensitivity/anaphylaxis (patient weighs 15kg to 29kg)

Premedications *(Prescriber, please list any premedication(s) you want your patient to have.)*
Drug _____ Directions _____
Drug _____ Directions _____

Quantity/Refills: Dispense quantity sufficient for medication days supply for loading dose, then 1 month ongoing for maintenance dose
☐ Other _____

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

*This form is a generic referral form that could be utilized for any Soliris provider and is meant to provide the pertinent information needed to process a Soliris referral.
**If nursing services will be required for the therapy administration, the home health nurse will call for additional orders per state regulations.
***ALL fields must be completed to expedite prescription fulfillment.
If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ _____ _____ _____
Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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