Prescription & Enrollment Form

Soliris® (eculizumab)

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current patient

Patient's first name ____________________
Last name ____________________ Middle initial _____
Date of birth ____________________ ❑ Male ❑ Female
Street address ____________________ Apt # ________
City ____________________ State ________ Zip ________
Parent/guardian (if applicable) ____________________
Cell phone ____________________ Other phone ____________________
E-mail address ____________________
Patient's primary language: ❑ English ❑ Other If other, please specify ____________

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company ____________________ Phone ____________________
Insured's name ____________________
Insured's employer ____________________ Relationship to patient ____________
Identification # ____________________ Policy/group # ____________________
Prescription card: ❑ Yes ❑ No If yes, carrier ____________________
Policy # ____________________ Group # ____________________
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date medication needed ____________________
Prescriber's first name ____________________ Last name ____________________
Prescriber's title ____________________
If NP or PA, under direction of Dr. ____________________
Office contact and title ____________________
Office contact e-mail ____________________
Office/clinic/institution name ____________________
Clinic/hospital affiliation ____________________
Street address ____________________ Suite # ____________
City ____________________ State ________ Zip ________
Phone ____________________ Fax ____________________
NPI # ____________________ License # ____________________
Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic
Is prescriber enrolled with One Source: ❑ Yes ❑ No If no, call 888.765.4747.
Prescriber must be certified by the Soliris REMS program before prescribing.

3 CLINICAL INFORMATION

Primary ICD-10: ❑ D59.5 PNH ❑ D59.3 aHUS ❑ G70.00 anti-AchR+ gMG
❑ Other ____________________
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 ____________________

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Soliris® (eculizumab)	300 mg/30 mL	❑ **Loading dose:** ______ mg IV every ______ weeks for ______ weeks. ❑ **Maintenance dose:** ______ mg IV every ______ weeks. ____________________	**Loading dose:** ❑ Quantity sufficient ❑ No refills **Maintenance dose:** Dispense: ❑ 1-month supply ❑ Other ____________ Refills ____________

Dilution and infusion rate

❑ **Loading dose:** ❑ Dilute Soliris with Normal Saline as directed per manufacturer guidelines to a final concentration of 5 mg/mL.
❑ If different: list here ____________________
If adult patient: ❑ Infusion rate: Infuse dose over 35 minutes.
❑ If different, please list here: Infuse dose over ____________.
If pediatric patient: ❑ Infusion rate: Please list here: Infuse dose over ____________.

❑ **Maintenance dose:** ❑ Dilute Soliris with Normal Saline as directed per manufacturer guidelines to a final concentration of 5 mg/mL.
❑ If different: list here ____________________
If adult patient: ❑ Infusion rate: Infuse dose over 35 minutes.
❑ If different, please list here: Infuse dose over ____________.
If pediatric patient: ❑ Infusion rate: Please list here: Infuse dose over ____________.

❑ 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

❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, IV tubing, etc. to administer the therapy.
❑ Prescriber, please check here to authorize prescription items needed to home administer Soliris such as:
Sodium Chloride 0.9% 250 mL, Sodium Chloride 0.9% flushes 10 mL.
Note: (if port IV access, additional Heparin flushes may be sent)
Prescriber please select: Heparin flushes ❑ 100 units/mL 5 mL or ❑ 10 units/mL 5 mL

Quantity: Quantity sufficient for medication days supply
Refills: Quantity sufficient for medication days supply

Is your patient new to therapy? ❑ Yes ❑ No
NOTE: The first or initial Soliris dose must be administered in a medical facility for patients who are new to therapy. After that, subsequent doses can be home infused.
Initial infusion location name ____________________ Initial infusion location phone number ____________________

Medicate with: ❑ Epipen/Epinephrine 0.3 mg Auto Injector IM as needed for anaphylaxis (patient weighs greater than or equal to 30 kg)
❑ Epipen/Epinephrine JR 0.15 mg/0.3 mL Auto injector IM as needed for anaphylaxis (patient weighs 15 kg to 29 kg)

Quantity: Quantity sufficient for medication days supply
Refills: Quantity sufficient for medication days supply

Premedications *(Prescriber, please list any premedication(s) you want your patient to have.)*
Drug ____________________ Directions ____________________
Drug ____________________ Directions ____________________
None ____________________

Quantity: Quantity sufficient for medication days supply
Refills: Quantity sufficient for medication days supply

Nursing Orders

Lab Orders

❑ 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.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

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

PHYSICIAN SIGNATURE REQUIRED

____________ 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.

*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.

Please fax completed form to your drug therapy team at 888.302.1028. To reach your team, call toll-free 844.516.3319.

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

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