Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Soliris® (eculizumab) Standard Plan of Treatment for Neuromyelitis Optica Spectrum Disorder

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	G36.0 - Neuromyelitis Optica Spectrum Disorder	☐	
☐	_____- Other:_____		

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	History & Physical/Tried and failed therapies	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	**REQUIRED:** Documentation of meningococcal vaccine (MenACWY AND MenB) at least 2 weeks prior to start of therapy		**IF ORDER CHANGE:** ☐ **Continue current order until insurance approved**

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive eculizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, presents with any symptoms of meningococcal infections, and/or surgery.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*FDA labeling does not suggest any premedication prior to infusion

IV	Diphenhydramine	◯ 25mg	◯ 50mg					
	Methylprednisolone	◯ 40mg	◯ 125mg	◯ Other:				
	Famotidine	◯ 20mg	◯ 40 mg					
	Other:	◯						
PO	Acetaminophen	◯ 325mg	◯ 500mg	◯ 650mg	◯ 1000mg			
	Famotidine	◯ 20mg	◯ 40mg					
	Diphenhydramine	◯ 25mg	◯ 50mg					
	Fexofenadine	◯ 60mg	◯ 180mg					
	Cetirizine	◯ 10mg						
	Loratadine	◯ 10mg						
	Other:	◯						

MEDICATION:

☑ Soliris® (eculizumab) IV given over 35 minutes diluted in NS per FDA labeling suggestions

If the infusion is slowed, the total infusion time should not exceed 2 hours.

Follow each infusion with a 1 hour post infusion monitoring

SPECIAL/OTHER LAB ORDERS:

◯ _____

_____

FREQUENCY/DOSE:

◯ Induction: 900mg IV given weekly for 4 weeks

◯ Maintenance (to begin at week 5 if receiving induction): 1200mg IV given once every 2 weeks

◯ Other:_____

Prescriber must be enrolled in the Soliris (REMS) program, at 1 888 765 4747 or at www.solirisrems.com.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

Dispense as written/Brand medically necessary	Substitution permitted	

ACCURX
INFUSION CENTER
A PALMETTO INFUSION COMPANY

Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

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