

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Soliris® (eculizumab) Standard Plan of Treatment for aHUS

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:
<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

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

D59.3 - Atypical Hemolytic Uremic Syndrome (aHUS)	D59.4 - Other non autoimmune hemolytic anemias (including microangiopathic hemolytic anemia)
D58.8 - Other specified hereditary hemolytic anemias	
D59.8 - Other acquired hemolytic anemias	
- Other:	

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		IF ORDER CHANGE:
5	Documented meningococcal vaccine administration (Both MenACWY AND MenB)		Continue current order until insurance approved

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

MEDICATION:

Soliris® (eculizumab) IV given over 35 minutes diluted in NS according to FDA labeling instructions

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:

<input type="checkbox"/>	
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FREQUENCY/DOSE:

<input type="checkbox"/>	Induction: 900mg IV weekly for 4 weeks
<input type="checkbox"/>	Maintenance (to begin at week 5 if receiving induction): 1200mg IV every 2 weeks
<input type="checkbox"/>	Other: _____

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

<input checked="" type="checkbox"/>	Refills x 12 months unless noted otherwise here:
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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
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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