Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

SOLIRIS (EXULIZUMAB)
INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis and including past tried and/or failed therapies intolerance, outcomes or contraindications to conventional therapy
- ☐ Positive serologic test for anti-AChR antibodies (if Myasthenia Gravis diagnosis)

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

- ☐ Paroxysmal nocturnal hemoglobinuria (PNH) (ICD-10: _____)
- ☐ Atypical hemolytic uremic syndrome (aHUS) (ICD-10: _____)
- ☐ Myasthenia Gracis (gMG) with AchR antibody positive (ICD-10: _____)

J Code: J1300

SOLIRIS ORDERS

Pt. Weight _____ kg

Adult Dosing:

☐ PNH
600mg IV weekly for first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every 2 weeks thereafter

☐ aHUS and gMG
900mg IV weekly for first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter

Required:

☐ Yes ☐ No - Patient has had the meningococcal vaccine

☐ Yes ☐ No - Patient is enrolled in Soliris REMS program

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	