



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

**INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)**

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

**CLINICAL INFORMATION**

Primary ICD-10 Code (Please Specify Diagnosis): \_\_\_\_\_

Secondary ICD-10 Code (Please Specify Diagnosis): \_\_\_\_\_

MG-ADL\* score: \_\_\_\_\_ Has the patient received Meningitis vaccination(s)?  Yes  No Date of vaccination(s): \_\_\_\_\_

Please check this box if the patient has declined vaccination Reason: \_\_\_\_\_

Adverse reactions with previous Soliris treatments?  No  Yes *If yes, Reason/Date:* \_\_\_\_\_

Please check to confirm: The patient is enrolled in the SOLIRIS REMS program; The patient has been counseled about the risks of meningococcal infection; The patient has received information and a Patient Safety Card about the symptoms and risks of meningococcal infection.

**SOLIRIS® ORDERS**

Prescription type:  New start  Restart  Continued therapy Total Doses Received: \_\_\_\_\_ Date of Last Injection/Infusion: \_\_\_\_\_

Medication	Strength	Dose/Frequency	Refills
<input type="checkbox"/> Soliris® (eculizumab)	<input type="checkbox"/> 300mg/30mL	<input type="checkbox"/> Loading dose: _____ mg IV every _____ weeks for weeks. <input type="checkbox"/> Maintenance dose: _____ mg IV every _____ weeks. <input type="checkbox"/> Other: _____	_____

**SIGNATURE**

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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