TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

Return Completed Form
To: 888.898.9113

Soliris Order

PATIENT INFORMATION (Complete or fax existing chart)			PRESCRIBER INFORMATION	
Patient Name:			Prescriber Name:	
Address:			State License:	NPI#:
City, State, Zip:			DEA:	Phone:
Phone:	2nd Phone:		Address:	Fax:
DOB:	Gender: ☐ Male ☐ Female		City, State, Zip:	
Weight:	Ht:	Date:	Contact Person:	Phone:
ICD-10 code: Diagnosis:				
Allergies:				
Neisseria Meningitis Vaccination Date:				

INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)			
Primary Insurance:		RX Card (PBM):	
City, State, Zip:		BIN:	PCN:
Plan#	Group#	City, State, Zip:	
Phone:		Plan#	Group#

PRESCRIPTION / ADMINISTRATION			
Medication	**Dose**	**Directions**	**Refills**
Induction Dosing	☐ 600 mg IV ☐ 900 mg IV ☐ 1200 mg IV	Weekly for the first 4 weeks	
Transition Dosing	☐ 900 mg IV ☐ 1200 mg IV	Fifth dose 1 week after induction dosing	
Maintenance Dosing	☐ 900 mg IV ☐ 1200 mg IV	Every 2 weeks following transition dosing	

SIGNATURE

× _____ Date: _____

Product Substitution Permitted