

# 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:		2 <sup>nd</sup> Phone:		Address:	Fax:
DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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	<input type="checkbox"/> 600 mg IV <input type="checkbox"/> 900 mg IV <input type="checkbox"/> 1200 mg IV		Weekly for the first 4 weeks		
Transition Dosing	<input type="checkbox"/> 900 mg IV <input type="checkbox"/> 1200 mg IV		Fifth dose 1 week after induction dosing		
Maintenance Dosing	<input type="checkbox"/> 900 mg IV <input type="checkbox"/> 1200 mg IV		Every 2 weeks following transition dosing		
SIGNATURE					
x _____ Date: _____ Product Substitution Permitted					

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