LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 10 CODE

☐ Atypical Hemolytic Uremic Syndrome (aHUS)	ICD 10 Code: D59.3
☐ Myasthenia Gravis, Aceytlcholine Receptor Antibody Positive	ICD 10 Code: G70.00 ____
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)	ICD 10 Code: D59.5
☐ Neuromyelitis Optica (NMO), Aquaporin 4 Antibody Positive	ICD 10 Code: G36.0
☐ Other:_____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ The signed order form by the provider	☐ Clinical/Progress notes (must be within 1 year)
☐ Patient demographics AND insurance information	☐ Labs and tests supporting primary diagnosis
☐ Prior authorization with reference number	☐ Aquaporin 4 Antibody Test results (if NMO)
☐ Acetylcholine Receptor Antibody test results (if Myasthenia Gravis)	☐ Documentation of meningococcal vaccines
Pt may be required to submit a pregnancy test prior to treatment	

List of tried and failed therapies, including duration of treatment:

_____

Is your patient enrolled in the Soliris-REMS program? ☐ Yes ☐ No

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____

Dosing for aHUS, Myasthenia Gravis and NMO	☐ J1300 Soliris 900mg IV once weekly for 4 weeks, followed by 1200mg IV at week 5, then 1200mg IV every 2 weeks thereafter ☐ J1300 Soliris _____mg IV every _____
Dosing for PNH	☐ J1300 Soliris 600mg IV once weekly for 4 weeks, followed by 900mg IV at week 5, then 900mg IV every 2 weeks Thereafter ☐ J1300 Soliris _____mg IV every _____

Duration: ☐ x6 months ☐ x 1 year ☐ _____doses

PREMEDICATION/LABS

☐ Acetaminophen _____mg PO PRN	☐ CBC ☐ prior to each infusion or ☐ Frequency: _____
☐ Benadryl _____mg PO or IV	☐ CMP ☐ prior to each infusion or ☐ Frequency: _____
☐ Methylprednisolone _____ slow IV push	☐ Other: _____ Date:_____
☐ Other: _____	

ADDITIONAL ORDERS/INFORMATION

PRESCRIBER INFORMATION

Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS – SOLIRIS (EXULIZUMAB)