LivWell INFUSIONS

Soliris and Biosimilars

Fax 888 511-7654 *Phone 888 864-7341*

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ☐ G70.00 Myasthenia gravis without (acute) exacerbation
- ☐ G70.01 Myasthenia gravis with (acute) exacerbation
- ☐ G36.00 Neuromyelitis optical (NMOSD)
- ☐ Other _____

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

SOLIRIS ORDER

Choose a Medication: ◯ **Soliris** ◯ **Bkemv** ◯ **Epysqli**

Dosage & Frequency:

- ◯ 600 mg weekly for the first 4 weeks, 900mg for the fifth dose one week later 900 mg every 2 weeks thereafter (PNH indication)
- ◯ 900 mg weekly for the first 4 weeks, 1200 mg for the fifth dose 1 week later 1200 mg every 2 weeks thereafter (aHUS indication)

Date of last Infusion: _____

Required:

- ☐ Patient has had the meningococcal vaccines (both MenACWY and MenB)
- ☐ Prescriber is enrolled in Ultomiris REMS Program

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____