Prescription & Enrollment Form

Soliris® (eculizumab)

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current patient

Patient's first name _____
Last name _____ Middle initial _____
Date of birth _____ ❑ Male ❑ Female
Street address _____ Apt # _____
City _____ State _____ Zip _____
Parent/guardian (if applicable) _____
Cell phone _____ Other phone _____
E-mail address _____
Patient's primary language: ❑ English ❑ Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
Insured's name _____
Insured's employer _____ Relationship to patient _____
Identification # _____ Policy/group # _____
Prescription card: ❑ Yes ❑ No If yes, carrier _____
Policy # _____ Group # _____
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date medication needed _____
Prescriber's first name _____ Last name _____
Prescriber's title _____
If NP or PA, under direction of Dr. _____
Office contact and title _____
Office contact e-mail _____
Office/clinic/institution name _____
Clinic/hospital affiliation _____
Street address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____
Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic
Is prescriber enrolled with One Source: ❑ Yes ❑ No If no, call 888.765.4747.
Prescriber must be certified by the Soliris REMS program before prescribing.

3 CLINICAL INFORMATION

Primary ICD-10: ❑ D59.5 PNH ❑ D59.3 aHUS ❑ G70.00 anti-AchR+ gMG
❑ Other _____
Weight _____kg/lbs Height _____cm/in Date recorded _____
❑ NKDA ❑ Known drug allergies _____
Concurrent meds _____
Adverse reactions with previous Soliris treatments? _____
Has the patient received Meningitis vaccination? ❑ Yes ❑ No
Date of vaccination _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Soliris® (eculizumab)	300mg/30mL	❑ **Loading dose:** _____ mg IV every _____ weeks for _____ weeks. ❑ **Maintenance dose:** _____ mg IV every _____ weeks. ❑ Other directions, please list here: _____	**Loading dose:** ❑ Quantity sufficient ❑ No refills **Maintenance dose:** Dispense: ❑ 1-month supply ❑ Other _____ Refills _____

Dilution and infusion rate

❑ **Loading dose:** ❑ Dilute Soliris with Normal Saline as directed per manufacturer guidelines to a final concentration of 5mg/mL.
❑ If different: list here _____
If adult patient: ❑ Infusion rate: Infuse dose over 35 minutes.
❑ If different, please list here: Infuse dose over _____.
If pediatric patient: ❑ Infusion rate: Please list here: Infuse dose over _____.

❑ **Maintenance dose:** ❑ Dilute Soliris with Normal Saline as directed per manufacturer guidelines to a final concentration of 5mg/mL.
❑ If different: list here _____
If adult patient: ❑ Infusion rate: Infuse dose over 35 minutes.
❑ If different, please list here: Infuse dose over _____.
If pediatric patient: ❑ Infusion rate: Please list here: Infuse dose over _____.

❑ Other instructions

Complete the below section if assistance from Accredo is requested in the coordination of your patient's infusion therapy

Is Accredo home nursing service requested? ❑ Yes ❑ No Vascular access: ❑ Peripheral ❑ Central ❑ Port

❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, IV tubing, etc. to administer the therapy.
❑ Prescriber, please check here to authorize prescription items needed and directions for use to home administer Soliris such as:
Sodium Chloride 0.9% 250mL (for dilution of 10mg/mL vial) Note: A different size bag could be dispensed depending on stock availability.
❑ **PERIPHERAL Access:** Sodium Chloride 0.9% flushes 10mL: Flush with 3mL before and after infusion or as needed for line patency.
❑ If different, please list here _____
❑ **PORT/CENTRAL Access:** Sodium Chloride 0.9% flushes 10mL: Flush with 5mL before and after infusion or as needed for line patency.
Heparin flushes 10 units/mL 5mL: Flush with 5mL as needed for final flush.
❑ If different, please list here _____

Quantity: Quantity sufficient for medication days supply
Refills: Quantity sufficient for medication days supply

Is your patient new to therapy? ❑ Yes ❑ No **NOTE:** The first or initial Soliris dose must be administered in a medical facility for patients who are new to therapy. After that, subsequent doses can be home infused. Initial infusion location name _____ Initial infusion location phone number _____

Medicate with: ❑ Epipen/Epinephrine 0.3mg Auto Injector – Inject dose per packaging for anaphylaxis (patient weighs greater than or equal to 30kg)
❑ Epipen/Epinephrine JR 0.15mg/0.3mL Auto injector – Inject dose per packaging for anaphylaxis (patient weighs 15kg to 29kg)

Quantity: Quantity sufficient for medication days supply
Refills: Quantity sufficient for medication days supply

Premedications *(Prescriber, please list any premedication(s) you want your patient to have.)*
Drug _____ Directions _____
Drug _____ Directions _____
None _____

Quantity: Quantity sufficient for medication days supply
Refills: Quantity sufficient for medication days supply

Nursing Orders

Lab Orders

❑ Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy. If nursing services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited. Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**) PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____
Date Dispense as written Date Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

*This form is a generic referral form that could be utilized for any Soliris provider and is meant to provide the pertinent information needed to process a Soliris referral. **If nursing services will be required for the therapy administration, the home health nurse will call for additional orders per state regulations. ***ALL fields must be completed to expedite prescription fulfillment.

Please fax completed form to your drug therapy team at 888.302.1028. To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.