Please fax both pages of completed form to your team at 833.951.1686.

To reach your team, call toll-free 800.442.5781.

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

Prescription & Enrollment Form

Soliris® (eculizumab)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: ☐ Male ☐ Female Preferred pronouns _____ Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ E-mail _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): ☐ D59.5 Paroxysmal nocturnal hemoglobinuria ☐ D59.3 Hemolytic-uremic syndrome ☐ D59.32 Hereditary hemolytic-uremic syndrome ☐ D59.39 Other hemolytic uremic syndrome ☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G70.01 Myasthenia Gravis with (acute) exacerbation ☐ G36.0 Neuromyelitis optica ☐ D58.8 Other specified hereditary hemolytic anemias ☐ D59.4 Other non-autoimmune hemolytic anemias (including microangiopathic hemolytic anemia)

☐ D59.8 Other acquired hemolytic anemias ☐ Other _____

MG-ADL* score (if known) _____ 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 _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

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 for medication days supply ☐ No refills **Maintenance dose:** ☐ 1-month supply ☐ Other: _____ Refills _____

Dilution and infusion rate

☐ **Loading dose:**
- ☐ Dilute Soliris with selected diluent 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 selected diluent 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 _____.

Check one (0.9% Sodium Chloride will be used if no box is checked):

☐ 0.9% Sodium Chloride Injection ☐ 0.45% Sodium Chloride Injection ☐ 5% Dextrose in Water Injection ☐ Ringer's Injection

☐ 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 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

Hypersensitivity/Anaphylaxis Stop infusion
Medicate with: ☐ Epipen/Epinephrine 0.3mg Auto Injector – Stop infusion and inject dose per packaging for hypersensitivity/anaphylaxis (patient weighs greater than or equal to 30kg) **OR** ☐ Epipen/Epinephrine JR 0.15mg/0.3mL Auto injector – Stop infusion and inject dose per packaging for hypersensitivity/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.

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

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ _____ _____ _____

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.

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Prior Authorization Checklist
Myasthenia Gravis

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients.[1] Coverage criteria may vary by payer.

Referral Form (not required for electronic prescriptions)	
	Completed myasthenia gravis referral form (available at accredo.com)
	Copies of front and back of all medical insurance and prescription benefit cards
Clinical Documents	
	History and Physical (H&P) and progress notes (within past 6 months)[2] Note: Diagnosis of the disorder must be unequivocal
Myasthenia Gravis (MG)	
	Tensilon test results
	Tried and failed medications, or has contraindication to immunosuppressant therapies (e.g., Mestinon®/corticosteroids/azathioprine/cyclosporine/mycophenolate)
	Ongoing immunoglobulin (Ig) treatment must be documented in H&P and progress notes[2]
	Myasthenic Panel (MG Testing)
	History and Physical (H&P) and progress notes presenting acute myasthenic crisis and decompensation (respiratory failure or disabling weakness). Include Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL)
	Clinical assessment that indicates eye muscle weakness, ptosis or swallowing issues
	Medication is prescribed by or in consultation with a neurologist

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.

1. This myasthenia gravis checklist is based on Medicare Part D guidelines and evidence of disease symptoms related to myasthenia gravis.
2. Ongoing management and documentation requirements:
   a. Initial improvement and continued need must be meticulously documented in progress notes
   b. All weaning must be attempted and documented as either amount or frequency

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