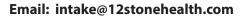
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





SOLIRIS ORDER FORM					
Date:		ICD-10 Code:		Therapy Status	
Patient Name:		Allergies:		☐ New Start	
Date of Birth:		Weight:Ibs OR	Continuing Therapy: Last Dose:		herapy: Last Dose:
PROVIDER INFORMATION					
Ordering P	rovider:	F	Provider Fax:		
Provider NPI:			Provider Address:		
Provider Phone:					
MEDICATION ORDER					
	For adult patients with aHUS, gMG, NMOSD:				Please include the following vaccine dates required for infusion. Primary vaccine series should be completed two weeks prior to start of therapy. Continued monitoring of booster vaccine administration and scheduling will be the responsibility of the prescriber:  ✓ MenACWY and MenB vaccine
	☐ Initiation: Infuse 900mg IV over 35 minutes weekly x 4 weeks, then 1200mg IV at week 5.				
	☐ Maintenance: Infuse1200mg IV over 35 minutes every 2 weeks.		Retills for	one year from	
Soliris	For adult patients with PNH:		indica	ted below.	
		□ Infuse 600mg IV over 35 minutes weekly x 4 weeks, then 900mg IV at week 5.		Refills	
	☐ Maintenance: Infuse 90 2 weeks.	00mg IV over 35 minutes every	,	administration dates	
PRE-MEDICATIONS					
<u>Oral</u> <u>IV</u>					
□ Acetaminophen:325mg500mg650mg			□ Dexamethasone:4mg8mg		
□ Loratadine: 10mg			□ Diphenhydramine:25mg50mg		
□ Cetirizine: 10mg			□ Famotidine:20mg40mg		
□ Diphenhydramine:25mg50mg			☐ Methylprednisolone: 125mg ☐ Hydrocortisone: 100mg		
☐ Famotidine:20mg40mg			☐ Ondansetron:4mg8mg		
□ Ibuprofen: 200mg400mg600mg □ Ondansetron:4mg8mg			□ Other:		
□ Ondansetron:4mg 8mg □ Other:					
LAB ORDERS (please indicate any labs to be drawn and frequency)			OTHER REQUIRED DOCUMENTATION		
			(Please fax this signed order form, along with the following documents to 800-223-4063)		
			History & Physical, Last Office Visit Note		
			Patient Demographics and Insurance Information		
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**			Medication List     Recent Lab Work		
By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)  By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.					
Dispense as Written:			Substitution Allowed:		
Prescriber Nar	me	Date	Prescriber Na	me	 Date