SOLIRIS REFERRAL FORM

Date: _____

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

Needs by Date: _____ Ship to ☐ Patient's Home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug cards)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

DIAGNOSIS & CLINICAL ASSESSMENT *(Fill in below or attach lab work)*

☐ New to Therapy ☐ Currently on Therapy ☐ Date of Last IVIG Infusion: _____ ☐ IVIG Dosing Regimen: _____

Diagnosis: ☐ G70.00 Myasthenia Gravis without (acute) exacerbation ☐ G70.01 Myasthenia Gravis with (acute) exacerbation ☐ in crisis

☐ D59.3 atypical Hemolytic Uremic Syndrome (aHUS) ☐ D59.5 PNH ☐ G36.0 Neuromyelitis Optica **Date of Diagnosis**: _____

Current Weight: _____ **Date**: _____ **Allergies**: _____ **Date of Meningococcal Vaccination**: _____

Previously on PLEX treatment ☐ Yes ☐ No **Date of last treatment**: _____ **Is patient AchR antibody positive?** ☐ Yes ☐ No

Is the Patient Anti-Aquaporin-4 (AQP4) antibody positive? ☐ **Yes** ☐ **No** **Notes / Comments**: _____

Soliris® (Eculizumab) for gMG or NMOSD

Dose / Strength	Directions	Quantity	Refills
☐ Injection: 300mg / 30mL (10mg/mL) in single-dose vial (3)	☐ **For treatment of Myasthenia Gravis:** ☐ 900mg weekly for the first 4 weeks, followed by ☐ 1200mg for the fifth dose 1 week later, then ☐ 1200mg every 2 weeks thereafter. ☐ **For treatment of Neuromyelitis Optica Spectrum Disorder (NMOSD):** ☐ 900mg weekly for the first 4 weeks, followed by ☐ 1200mg for the fifth dose 1 week later, then ☐ 1200mg every 2 weeks thereafter.	_____	☐ 1-year supply _____ ☐ 1-year supply

Soliris® (Eculizumab)

Dose / Strength	Directions	Quantity	Refills
☐ Injection: 300mg / 30mL (10mg/mL) in single-dose vial (3)	☐ **For treatment of aHUS – 18 years or older:** ☐ 900mg weekly for the first 4 weeks, followed by ☐ 1200mg for the fifth dose 1 week later, then ☐ 1200mg every 2 weeks thereafter. ☐ **For treatment of PNH – 18 years or older:** ☐ 600mg weekly for the first 4 weeks, followed by ☐ 900mg for the fifth dose 1 week later, then ☐ 900mg every 2 weeks thereafter.	_____	☐ 1-year supply _____ ☐ 1-year supply

Other/Notes: _____

Prescriber Signature: _____ **DAW (Dispense as Written)** ☐ Y ☐ N **Date:** _____

If Century Specialty Script is the patient's choice, please Call, Fax, Mail, or send an Electronic Prescription to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353