SOLIRIS® (eculizumab) Referral Form

Patient Preferred Clinic (select one): _____

VIVO infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per VIVO protocols.

LABORATORY ORDERS

☐ CBC ☐ At each dose ☐ Every _____
☐ CMP ☐ At each dose ☐ Every _____
☐ CRP ☐ At each dose ☐ Every _____
☐ OTHER

REQUIRED DOCUMENTATION

- ☐ **Patient Demographics**
- ☐ **Insurance Card/Information**
- ☐ **Progress Notes Supporting DX**
- ☐ **Current Medication List and H&P**
- ☐ **MG-ADL Score _____**
- ☐ **Positive AQP4**
- ☐ **Patient has had the meningococcal vaccines (both MenACWY and MenB)**
- ☐ **MGFA Classification ____**
- ☐ **Complete Metabolic Panel**
- ☐ **Positive AchR (gMG)**

SOLIRIS THERAPY ADMINISTRATION

PNH DIAGNOSIS

☐ Initial Dosing: 600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every 2 weeks thereafter

☐ Maintenance Dose: 900mg IV every 2 weeks x 1 year

aHUS, gMG, and NMOSD DIAGNOSIS

☐ Initial Dosing: 900mg IV weekly for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter

☐ Maintenance Dose: 1200mg IV every 2 weeks

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Fax Numbers

☐ Colorado: 303-418-4679
☐ Florida: 904-930-4211
☐ Texas: 469-340-0044
☐ Nevada: 702-489-5744
☐ New Jersey: 609-955-3711
☐ Ohio: 216-400-0674
☐ Oklahoma: 918-770-4421
☐ Massachusetts: 203-724-4838
☐ Pennsylvania: 215-399-9244
☐ New York: 203-724-4838
☐ Connecticut: 203-724-4838

Have a Question? (720) 902-4111

Email Referrals To: referrals@vivoinfusion.com

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