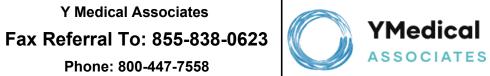
## **SOLIRIS REFERRAL FORM**

## Y Medical Associates



Date:	Ph	one: 800-447-7	558		
Needs by Date:	Ship to Patient's	Home Prescr	iber 1 <sup>st</sup> Order On	ly Prescriber A	All Orders
Patient Name: Address: City, State, Zip: Home Phone: Cell Phone: Date of Birth:	Gender: M F  INFORMATION (Please attach the	Address: City, State, Zi Phone: DEA#: Contact Perso	p:	Fax: NPI#:	
Primary Insurance: Secondary Insurance: Prescription Card:	ID#:	ID#:		Group:	
New to Therapy Curre  Diagnosis: G70.00 Myas  D59.3 atypical Hemolytic  Current Weight:	DIAGNOSIS & CLINICAL ASSESS  Intly on Therapy Date of Last IVIG Infusion: thenia Gravis without (acute) exacerbation G  Uremic Syndrome (aHUS) D59.5 PNH G  — Date: Allergies: nent Yes No Date of last treatment:	IVIG E 70.01 Myasthenia Gra 36.0 Neuromyelitis Op Date of Mer	Dosing Regimen: avis with (acute) exact otica Date of Diagno ningococcal Vaccin	perbation in crisis psis:	
	aporin-4 (AQP4) antibody positive?				
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Soliris® (Eculizui				
Dose / Strength	Directions		Qua	ntity	Refills
□ Injection: 300mg / 30mL (10mg/mL) in single-dose vial (3)	<ul> <li>□ For treatment of Myasthenia Gravis</li> <li>□ 900mg weekly for the first 4 weeks</li> <li>□ 1200mg for the fifth dose 1 week la</li> <li>□ 1200mg every 2 weeks thereafter.</li> <li>□ For treatment of Neuromyelitis Optinisorder (NMOSD):</li> <li>□ 900mg weekly for the first 4 weeks</li> <li>□ 1200mg for the fifth dose 1 week la</li> <li>□ 1200mg every 2 weeks thereafter.</li> </ul>	i, followed by later, then ica Spectrum -, followed by			□ 1-year supply
Dose / Strength	Soli Directions	ris® (Eculizum	ab) Qua	ntity	Refills
☐ Injection: 300mg / 30mL (10mg/mL) in single-dose vial (3)	□ For treatment of aHUS – 18 years or □ 900mg weekly for the first 4 weeks □ 1200mg for the fifth dose 1 week la □ 1200mg every 2 weeks thereafter.  For treatment of PNH – 18 years or € 600mg weekly for the first 4 weeks 900mg for the fifth dose 1 week lat 900mg every 2 weeks thereafter.	, followed by ater, then  older: , followed by			□ 1-year supply □ 1-year supply
Other/Notes:					
Prescriber Signatu	re.	DAW (Diena	nse as Written)	□ Y □ N Date:	