ameripharma SPECIALTY CARE

Soliris® Enrollment Form

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Caregiver Name: _____ Relation to Patient: _____ Phone: _____

Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone: _____ Alternate: _____ Fax: _____ Email: _____

Needs by Date:_____ Ship to: ☐ Patient ☐ Office ☐ Other:_____

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis (ICD-10): ☐ D59.5 Paroxysmal Nocturnal Hemoglobinuria (PNH) ☐ D59.3 Atypical Hemolytic Uremic Syndrome (aHUS) ☐ G70.0 Generalized Myasthenia Gravis (gMG)

☐ Other Code: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Start Date	End Date

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other: _____

Diagnosis	Dose and Directions		Quantity	Refills
☐ Paroxysmal Nocturnal Hemoglobinuria (PNH)	☐ Dose Titration:	Month 1: Administer 600 mg via IV infusion every 7 days for 4 weeks	☐ 4-week supply	0
	☐ Maintenance Dosing:	Administer 900mg mg via IV INFUSION every 2 weeks starting week 5	☐ 4-week supply ☐ 12-week supply	☐ 1 year supply
☐ Atypical Hemolytic Uremic Syndrome (aHUS)	☐ Dose Titration:	Month 1: Administer 900 mg via IV infusion every 7 days for 4 weeks	☐ 4-week supply	0
	☐ Maintenance Dosing:	Administer 1,200 mg via IV infusion every 2 weeks starting week fve	☐ 4-week supply ☐ 12-week supply	☐ 1 year supply
☐ Generalized Myasthenia Gravis (gMG)	☐ Dose Titration:	Month 1: Administer 900 mg via IV infusion every 7 days for 4 weeks	☐ 4-week supply	0
	☐ Maintenance Dosing:	Administer 1,200mg via IV infusion every 2 weeks starting week 5	☐ 4-week supply ☐ 12-week supply	☐ 1 year supply

Preparation for Administration

Add eculizumab to an infusion bag and dilute with an equal volume of D5W, sodium chloride 0.9%, sodium chloride 0.45%, or Ringer's injection to a final concentration of 5 mg/mL (eg, 300 mg to a final volume of 60 mL, 600 mg to a final volume of 120 mL, 900 mg to a final volume of 180 mL, or 1,200 mg to a final volume of 240 mL). Gently invert bag to mix thoroughly; do not shake.

Assess vaccination status prior to initiation; patients must receive meningococcal vaccine at least 2 weeks prior to treatment initiation.

Meningococcal Conjugate Vaccine		
☐ Menactra® ☐ Menveo®	☐ (Up to 55 years) 0.5 mL IM single dose ☐ (Increased risk of infection) 0.5 mL IM as a 2-dose series given at least 8 weeks apart	☐ #1 ☐ #2
Serogroup B Meningococcal Vaccine		
☐ Bexsero®	☐ (25 years or younger) 0.5 mL IM as a 2-dose series 1 month apart	☐ #2
☐ Trumenba®	☐ (25 years or younger) 0.5 mL IM as a 2-dose series at 0, and 6 months	☐ #2
	☐ (25 years or younger) 0.5 mL IM as a 3-dose series at 0, 1 to 2, and 6 months	☐ #3

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above.
I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

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