BIOMATRIX SpRx

SOLIRIS®
REFERRAL FORM

TODAY'S DATE _____

☐ **CURRENT PATIENT** ☐ **NEW PATIENT**

PLEASE FAX REFERRAL FORM TO:

☐ **BiologicTx - NJ**
TEL: 877-567-8087 FAX: 877-567-8089

☐ **BiologicTx - CA**
TEL: 800-404-1963 FAX: 800-404-4595

☐ **BiologicTx - IL**
TEL: 888-892-7607 FAX: 877-567-8089

☐ **Decillion Healthcare**
TEL: 800-622-9321 FAX: 866-548-8849

☐ **Elwyn Specialty Care**
TEL: 855-359-9679 FAX: 610-545-6030

☐ **Factor Support Network**
TEL: 877-376-4968 FAX: 805-482-6324

☐ **Matrix Health**
TEL: 877-337-3002 FAX: 888-385-2805

☐ **Med Center Specialty Pharmacy**
TEL: 855-633-5633 FAX: 304-344-0655

☐ **MedEx BioCare**
TEL: 800-962-6339 FAX: 901-382-3091

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____
☐_____ #_____	☐_____ #_____	☐_____ #_____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Code: ☐ **D59.5** Paroxysmal Nocturnal Hemoglobinuria
☐ **D59.3** Atypical Hemolytic Uremic Syndrome
☐ Other: _____
☐ **G70.00** Myasthenia Gravis without acute exacerbation
☐ **G70.01** Myasthenia Gravis with acute exacerbation

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

PHYSICIAN ORDERS

☐ Transplant Related: Infuse Soliris® _____ mg IV x 1 initial dose, then _____ mg IV weekly starting day 8 for _____ doses, then _____ mg IV every 14 days for _____ doses or _____ months.
☐ PNH, aHUS, Myasthenia Gravis: Infuse Soliris® _____ mg IV every 7 days for the first 4 weeks, followed by one single dose of _____ mg 7 days after the 4th dose, and then _____ mg IV every 14 days for _____ doses or _____ months.
☐ Dilute Soliris® with NS or D5W to final concentration of 5mg/ml. Infuse over 35 minutes via gravity.
☐ Infusion needs to be completed in no longer than 2 hours.
☐ Other _____

PRE-MEDICATIONS

No pre-medication is recommended.

ANAPHYLAXIS/FLUSH/SUPPLY ORDERS

Anaphylaxis Kit: ☐ Adult
Flush Orders (PRN Catheter Maintenance): ☐ Saline 0.9% Flush 5ml ☐ Heparin Flush 10 units/ml - 5ml ☐ Heparin Flush 100 units/ml - 5ml
Supplies will be provided as per therapy requirements.

MENINGOCOCCAL VACCINE/ANTIBIOTIC ORDERS

Meningococcal Vaccine administered on _____ / _____ / _____. Recommended to be given at least two weeks prior to first dose of Soliris®, unless the risks of delaying Soliris® therapy outweigh the risks of meningococcal infection. In those instances, it is recommended to place patient on antibiotic prophylaxis therapy to cover the 2 weeks post vaccination.
☐ Antibiotic Therapy Orders: _____ Duration: _____ Days
☐ No Antibiotic Therapy

NURSING ORDERS

☐ Provide skilled nursing care to complete therapy.
☐ Screen patient for signs and symptoms of active infection and vaccination with meningococcal vaccine.
☐ Baseline Vital Signs: BP, HR, Temp prior to infusion, every 15 minutes until completion of infusion, and at 30 and 60 minutes during post infusion observation.
☐ Monitor patient for 1 hour after completion of infusion.
☐ Provide education regarding medication, disease state, adverse drug reactions, and administration. Observe for response to therapy.
☐ IV Access: _____ Location: _____
☐ Maintain IV Access according to company policy and procedures.

PLEASE INCLUDE THE FOLLOWING

☐ MD Prescription
☐ History of medications (tried and failed)
☐ Copy of Meningococcal vaccination, including date of vaccination
☐ Complete Patient History, including any previous transplants and dates, lab results
☐ Copy of insurance card (front and back)

COMMENTS

_____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS)_____ *Dispense as written* **Date**_____

Prescriber's Signature (signature required. NO STAMPS)_____ *Product Substitution Permitted* **Date**_____

Please visit **WWW.BIOMATRIXSPRX.COM** For more information