SOLIRIS REFERRAL FORM

Date: _____

HOMETECH ADVANCED THERAPIES

Fax Referral To: 855-884-9283

Phone: 855-494-3121

HOMETECH ADVANCED THERAPIES

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 card)*

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) **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

Notes / Comments: _____

Soliris® (eculizumab)

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.	☐ 4-week supply ☐ 4-week supply ☐ 12-week supply ☐ Other ☐ 4-week supply ☐ 12-week supply ☐ Other	☐ 1-year supply
	☐ **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.	☐ 4-week supply ☐ 4-week supply ☐ 12-week supply ☐ Other ☐ 4-week supply ☐ 12-week supply ☐ Other	☐ 1-year supply
	☐ **Other:** ☐ _____ ☐ _____	☐ _____ ☐ _____	☐ _____

Other/Notes: _____

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

If Hometech Advanced Therapies is the patient's choice, please Call-in, Fax, or Mail prescriptions to:
Hometech Advanced Therapies, 505 Elmwood Avenue, Sharon Hill, PA 19079 • Phone (855) 494-3121, Fax (855) 884-9283