RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Soliris Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

Soliris Medication Orders

Dosage

- _____ Induction: 900mg IV weekly for 4 doses
- _____ Maintenance: ___ 1200mg IV at week 5, then ___ 1200mg IV every 2 weeks thereafter
- _____ Other _____

Patient Weight: _____ Lbs or _____ Kg

Diagnosis with ICD 10 code **(REQUIRED)**

- Diagnosis: _____ Myasthenia Gravis ____ Atypical Hemolytic Syndrome _____Other _____
- ICD 10 code _____

Pre-Medication	Refills
● Tylenol _____mg ● Benadryl _____ mg __IV or ___PO	● Zero _____ ● Treatments for 1 year _____
● Solumedrol IV Push _____ mg ● Other _____	● Other _____

Required Documentation

○ **Insurance Cards (Front and Back)** ○ **Patient Demographics** ○ **Recent Progress Notes**
○ **Lab Results – CMP, CBC, Evidence of Meningococcal vaccine at least 2 weeks prior to first treatment**

Special Instructions/Notes

_____ _____

Prescribing Provider Signature **Date of Signature**