Allergy, Asthma & Immunology Center, P.C.
Infusion Services

www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
Have a Question? (855) 478-1528

SOLIRIS®ORDER FORM

(- Required Fields)*

____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

Locations:

-------Oklahoma-------
___ Tulsa

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐M ☐F
ADDRESS:		PHONE:	
WEIGHT: ☐LBS ☐KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

SOLIRIS ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

____ **Initial/Reload Dosing and Maintenance Dosing:** _____mg IV for the first 4 weeks, followed by ____ mg for the fifth dose 1 week later, then _____mg every 2 weeks thereafter

OR

____ Maintenance Dosing: _____mg/kg IV every _____ weeks

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____
Infusion will be administered per policy and protocols

REQUIRED DIAGNOSIS:

_____ Myasthenia Gravis (gMG)
_____ Paroxysmal Nocturnal Hemoglobinuria
_____ Atypical Hemolytic Uremic Syndrome
_____ Neuromyelitis Optica Spectrum Disorder(NMOSD)
_____ Other_____

***STAT REASON:**
(STAT request will be assessed per MPP policy and procedure)

Last Infusion: _____

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting
_____ Current Medication List and H&P
____ Positive AchR (gMG)
_____ Positive AQP4

_____ MG-ADL Score_____
_____ MGFA classification: _____

Did patient receive Meningococcal Vaccine?
_Yes _ _No

STANDING LAB ORDERS: _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

REVISION DATE- 04/2020