866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please contact us!
www.REPharmacy.com

Soliris Referral Form

Send your Rx to: (optional) ______________________

Date Medication Needed: ___________ Ship To: ( ) Patient's Home ( ) Prescriber's Office ( ) Pick-up (store location): ______________ Injection training by pharmacy? ☐

1. Patient Information

Patient Name: ______________ Birthdate: __________ Sex: ( ) Male ( ) Female Height: ______ ( ) cm. ( ) in. Weight: ______ ( ) lbs. ( ) kg.

Soc. Sec. #: __________ Preferred Phone: __________ Known Allergies: ______________

Address: ______________ City: __________ State: ________ Zip: ________

Alternate Caregiver Name: ______________ Preferred Phone: ______________

Date Shipment Needed: ______________ Email: ______________ Patient education kit? ( ) Yes ( ) No

Ship to: ☐ Patient ☐ Physician ☐ Other: __________ Teaching to be done at: ☐ Physician office ☐ Patient home (to be coordinated with RE Pharmacy)

2. Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Insurance provider: (please include copy of card) ______________ ID#: __________ Policy group#: __________ PCN#: __________

Name of insured: ______________ Phone: __________ Fax: __________

Employer: ______________ Relationship to patient: ☐ Self ☐ Other: __________

Carrier: __________ Policy group#: __________ Patient is eligible for Medicare Prescription Card: ( ) Yes ( ) No

3. Prescriber Information

Prescriber Name: ______________ State Lic.: __________ DEA#: __________ NPI#: __________

Address: ______________ Phone: __________ Fax: __________

City, State, Zip: ______________ REMS Program: ( ) Yes ( ) No Key Contact: __________ Phone: __________

4. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

Generalized Myasthenia Gravis: ( ) Yes ( ) No Age: > or equal 18 years old: ( ) Yes ( ) No

Paroxysmal Nocturnal Hemoglobinuria (PNH): ( ) Yes ( ) No Atypical Hemolytic Uremic Syndrome (aHUS): ( ) Yes ( ) No

Recent Meningococcal Vaccine: ( ) Yes ( ) No Date of Administration: ______________

Recent Antibiotic: ( ) Yes ( ) No Name of Antibiotic: ______________ Date: __________

AchR antibody positive: ( ) Yes ( ) No Allergies to Eculizumab) or other meds: ( ) Yes ( ) No Indicate: ______________

5. Past Medical History

Neisseria meningitidis infection: ( ) Yes ( ) No Any current or recent systemic infection: ( ) Yes ( ) No Indicate: ______________

Prior List of Medications: Any biologics? ( ) Yes ( ) No Indicate: ______________

6. Prescription Information

Medication and Strength	Dosing and Frequency		Qty.	Refills
☐ **Soliris** Soliris comes in injection: 300mg /30mL (10mg/mL) in single-dose vial	☐ **Genralized Myasthenia Gravis (gMG)**	☐ 900mg IV once a week for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later ☐ Maintenance: Then 1200mg every 2 weeks thereafter		
	☐ **Paroxysmal Nocturnal Hemoglobinuria (PNH)**	☐ 600 mg IV once a week for 4 weeks followed by 900 mg IV for the fifth dose 1 week later ☐ Maintenance: 900 mg IV every 2 weeks thereafter		
	☐ **Atypical Hemolytic Uremic Syndrome (aHUS)**	☐ 900 mg IV once a week for 4 weeks followed by 1200 mg IV for the fifth dose 1 week later ☐ Maintenance: 1200 mg IV every 2 weeks thereafter		

6. Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written ______________ **Date** __________ **Substitution Permissible** ______________ **Date** __________

# of Prescriptions: __________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

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