

Patient Information

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):			_____
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
Does the patient need interpreter services:		Yes	No

Provider Information

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip:

ICD-10 CODE

D59.5 Paroxysmal nocturnal hemoglobinuria (PNH) D58.9 Hereditary hemolytic anemia, unspecified
 G70.00 Myasthenia Gravis G36.0 Neuromyelitis optica spectrum disorder (NMOSD) Other: _____

Medication Order

No brand preference. AleraCare will select product based on payer policy. Brand preference: _____

Soliris (eculizumab)	Initiation therapy:	Maintenance therapy:
	600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every 2 weeks thereafter	900mg IV every 2 weeks 1200mg IV every 2 weeks
	900mg IV weekly for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter	Other: _____
Other: _____		

Meningococcal vaccination AleraCare will administer a Meningococcal Conjugate (MenACWY) Vaccine and a Serogroup B Meningococcal (MenB) Vaccine series.
 If not checked, then please submit documentation with meningococcal vaccination information.
 Urgent administration is needed and antibiotic prophylaxis was prescribed.

Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
Patient has received both of the required meningitis vaccines (MenACWY and MenB). Date(s) of vaccinations: _____			
Note: All patients are required to receive meningitis vaccinations at least 2 weeks prior to initiating Soliris unless initiation of Soliris is urgent. Please supply the vaccination records.			

Pre-Medication Order

acetaminophen (Tylenol)	500mg	650mg	1000mg PO	diphenhydramine (Benadryl)	25mg	50mg /	PO	IV
cetirizine (Zyrtec)	10mg PO			methylprednisolone (Solu-Medrol)	40mg IV		125mg IV	
loratadine (Claritin)	10mg PO			hydrocortisone (Solu-Cortef)	100mg IV			
Other: _____								
Dose: _____			Route: _____			Frequency: _____		

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)
Provider Name
Provider Signature
Date

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order

Patient Information

Patient Name:	DOB:	Sex:	M	F	Fasting:	Y	N
Patient Home Phone:	Patient Cell Phone:						
Emergency/Alternate Contact Name:	Emergency/Alternate Contact Phone:						

Lab Test (Please circle or write in ICD-10)

ALT	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE	J45.4, J45.3, L50.9, J45.40, J45.50
AST	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG	G35, G36.0
HEPATIC FUNCTION PANEL	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IMMUNOGLOBULIN QUANT IgG, IgM, IgA	G35, G36.0
BASIC METABOLIC PANEL	I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE	G35, G36.0
CALCIUM	M81.0, M81.8	IRON, TIBC, FER PNL	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (INCLUDES DIFF/PLT)	I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL	Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
CBC (H/H, RBC, WBC, PLT)s	I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	MAGNESIUM	I10, Z79.899, R25.2, E83.42, Z00.00
COMP METABOLIC PANEL	I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	PSA	R97.20, C61, N40.1, Z12.5, N40.0
CREATININE	M81.0, M81.8, G35	PROTHROMBIN TIME-INR	Z79.01, I48.91, I48.0, Z51.81
C-REACTIVE PROTEIN (CRP)	R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	TRANSFERRIN SATURATION	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
FERRITIN	D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	QUANTIFERON TB GOLD	Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
G6PD	M1A.9XX0, M1A.9XX1	TSH	E03.9, I10, E03.8, R53.83, E06.3, E05.00
GROWTH HORMONE	E22, C7A.1, E34	URIC ACID	M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT	D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID	M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C	E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX	E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)	

Frequency

Prior to each dose Yearly Other: Please Specify Below

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Provider Name

Provider Signature

Date

Provider Phone