



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____		Prescriber Name: _____	
Address: _____		State License: _____	
City, State, Zip: _____		NPI #: _____ Tax ID: _____	
Phone: _____ Alt. Phone: _____		Address: _____	
Email: _____ SS#: _____		City, State, Zip: _____	
Gender: ☐ M ☐ F Weight: _____ (lbs) Ht: _____		Phone: _____ Fax: _____	
Allergies: _____		Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)			
Primary Insurance: _____		Secondary Insurance (If Applicable): _____	
Plan #: _____		Plan #: _____	
Group #: _____		Group #: _____	
RX Card (PBM): _____		RX Card (PBM): _____	
BIN: _____ PCN: _____		BIN: _____ PCN: _____	
CLINICAL INFORMATION			
Primary ICD-10 Code (Please Specify Diagnosis): _____			
Secondary ICD-10 Code (Please Specify Diagnosis): _____			
MG-ADL* score: _____ Has the patient received Meningitis vaccination(s)? ☐ Yes ☐ No Date of vaccination(s): _____			
☐ Please check this box if the patient has declined vaccination Reason: _____			
Adverse reactions with previous Soliris treatments? ☐ No ☐ Yes If yes, Reason/Date: _____			
☐ Please check to confirm: The patient is enrolled in the SOLIRIS REMS program; The patient has been counseled about the risks of meningococcal infection; The patient has received information and a Patient Safety Card about the symptoms and risks of meningococcal infection.			
SOLIRIS® ORDERS			
Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
Medication	Strength	Dose/Frequency	Refills
☐ Soliris® (eculizumab)	☐ 300mg/30mL	☐ Loading dose: _____ mg IV every _____ weeks for weeks. ☐ Maintenance dose: _____ mg IV every _____ weeks. ☐ Other: _____	_____
Pre-Medication	Dose/Strength	Directions	
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed	
☐ Diphenhydramine	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR ☐ Inject contents of 1 vial IV prior to infusion or as directed	
☐ Methylprednisolone	☐ 40mg ☐ 100mg ☐ 125mg	☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion	
☐ _____	_____	_____	
INFUSION REACTION ORDERS			
Mild reaction protocol:			
☒ Diphenhydramine 25mg IV, one time, for pruritus.			
If symptoms worsen, see orders for moderate to severe reactions.			



Moderate reaction protocol:

- ☒ Acetaminophen 650mg PO, one time, for pyrexia or rigors
- ☒ Diphenhydramine 50mg IV, one time, for pruritus or urticaria
- ☒ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms

If symptoms worsen, see interventions for severe reactions

Severe reaction protocol: (Call 911 if initiated):

- ☒ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)
- ☒ Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- ☒ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis
- ☒ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms
- ☒ Epinephrine 0.3mg/0.3mL IM into mid-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen

FLUSHING & LOCKING ORDERS

Flushing Protocol (>66lbs/33kg)

PIV and Midline:

- ☒ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion

Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:

- ☒ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw

Locking Protocol (>66lbs/33kg)

PIV and Midline:

- ☒ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush

PICC:

- ☒ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush

Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:

- ☒ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush

**** May substitute Dextrose 5% in Water, or alternative, for 0.9% Sodium Chloride, when indicated due to incompatibility with medications being infused**

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____

Prescriber Signature

Date: _____

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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