HEARTLAND INFUSION

Fax to Heartland (1.865.862.4556)
Questions? Call (1.865.862.4557)

Soliris Order Form

Please fax completed form with patient demographics, front and back of insurance card(s), recent lab results, and recent office visit notes supporting diagnosis to 865.862.4556.

Type of Referral: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal **Location:** ☐ Jackson ☐ Knoxville ☐ Morristown ☐ Kingsport

PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: _____ Gender: (**check one**) ☐ M ☐ F

Home Phone: _____ Mobile Phone: _____

Email: _____ Last 4 of SS#: _____

Allergies: _____ Height: _____ Weight: _____

ICD-10 Diagnosis Code(s): _____ Date of Diagnosis: _____

TB Test (**circle one**): Skin Quantiferon Chest X-ray Result: _____ Date: _____

THERAPY ORDERS

☐ Induction: Administer Soliris (eculizumab) 600mg IV weekly for weeks 0-4; 900mg week 5; 900mg week 7 **OR**
Administer Soliris (eculizumab) 900mg IV weekly for weeks 0-4; 1,200mg week 5; 1,200mg week 7

☐ Maintenance: Administer ☐ Soliris (eculizumab) 900mg IV every 2 weeks **OR** ☐ Soliris (ustekinumab) 1,200 mg IV every 2 weeks

☐ Patient is required to stay for 60 minutes of observation post infusion

☐ Nursing per Heartland Nursing Procedures (including reaction management)

PRE-MEDICATION

☐ **No routine pre-medications required**

☐ Tylenol (acetaminophen) _____mg PO

☐ Zyrtec (cetirizine) 10mg PO

☐ Solu-Medrol (methylprednisolone) IV ☐ 40 mg, ☐ 125 mg, ☐ other _____mg

☐ Claritin (loratadine) 10mg PO

☐ Benadryl (diphenhydramine) _____mg ☐ PO ☐ IV

☐ Other: _____

LABORATORY ORDERS

☐ CBC w/ DIFF	☐ each infusion	☐ Other: _____
☐ CRP	☐ each infusion	☐ Other: _____
☐ CMP	☐ each infusion	☐ Other: _____
☐ ESR	☐ each infusion	☐ Other: _____
☐ Hepatic Panel	☐ each infusion	☐ Other: _____
☐ Renal Panel	☐ each infusion	☐ Other: _____
☐ Quantiferon TB (annually)		Due: _____
☐ Other: _____		

PRESCRIBER'S INFORMATION

Prescriber Name: _____

License #: _____ NPI: _____ DEA: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Contact: _____

Office Phone: _____ Office Fax: _____

Prescriber's Signature: _____