SOLIRIS (eculizumab) Referral Order Form

FAX (877) 637-6691

VASCO INFUSION
WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)* _____

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

SOLIRIS MEDICATION ORDERS

☐ Initial Dose: 900mg for first 4 weeks then 1200mg on week 5

☐ Maintenance Dose: 1200mg every 2 weeks

Refills: _____

INDICATION/DIAGNOSIS

☐ Generalized Myasthenia gravis
☐ Paroxysmal Nocturnal Hemoglobinuria
☐ Atypical Hemolytic Uremic Syndrome

***ICD-10_____required**

NOTES (ADDITIONAL INFO)

_____ _____
Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Insurance Cards (front and back) ☐ Demographic Sheet ☐ MGFA Clinical Classification Score ☐ MG Daily Living Score

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ AchR ☐ Meningitis vaccine: date of administration

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY