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Nashville, TN
F: 615-645-4791

Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
 Phone Number: _____ Email Address: _____
 Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
 Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Atypical Hemolytic Uremic Syndrome (aHUS) _____ Neuromyelitis Optica Spectrum Disorders (NMOSD)
 _____ Myasthenia Gravis (MG) _____ Paroxysmal nocturnal hemoglobinuria (PNH)
 _____ Other: _____

Please attach the following: 1. Clinical progress notes and H&P to support diagnosis 2. Copy of the patient's Insurance Card 3. Positive Serologic test results if appropriate for diagnosis (e.g. NMOSD or MG) 4. Patient has had the appropriate meningococcal vaccines Yes No
 5. Prescriber is enrolled in Soliris REM Program Yes No

Lab Orders: _____

Physician Information

Prescribing Physician: _____ Practice Name: _____
 Practice Phone: _____ Practice Fax: _____
 Email: _____ Office Contact: _____
 Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: SOLIRIS® (eculizumab)

PNH _____ # Refills (Recommend 15)

New Start: Infuse 600 mg IV weekly for 4 weeks, followed by 900 mg IV the following week and then 900 mg IV every 2 weeks thereafter

Maintenance Dose : Infuse 900 mg IV every two weeks

aHUS, gMG, NMOSD _____ # Refills (Recommend 15)

New Start: Infuse 900 mg IV weekly for 4 weeks, followed by 1200 mg IV the following week and then 1200 mg IV every 2 weeks thereafter

Maintenance Dose: Infuse 1200 mg IV every 2 weeks

Pre-Medication Orders: Acetaminophen 650 mg PO administered 30 min prior to infusion *adjust to patient's needs.
 Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician's NPI#

Physician's Address

Prescriber's Signature

Date

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRx Services, Inc. All rights reserved.