



Soliris – eculizumab

Member Information

Name _____
Enrollment / Cardholder ID _____
Group / Plan _____
Birth Date _____
Address _____
City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent
Gender (Circle)
Male Female
AGE: _____

Practitioner Information

Name _____
Agent / Contact Name _____
Specialty _____
Office / Clinic Name _____
Address _____
City State Zip _____
Phone () - _____
Fax () - _____
Email _____ @ _____

**Primary Diagnosis Condition /
Diagnosis Related – Reason for Request**

Diagnosis of paroxysmal nocturnal hemoglobinuria? **Y / N**

Has the patient received, or will receive, a meningococcal vaccine, at least 2 weeks prior to initiation of eculizumab therapy and revaccinated according to current medical guidelines for vaccine use. **Y / N**

Dosage:

- 600 mg every 7 days for the first 4 weeks
- followed by 900 mg for the fifth dose 7 days later
- then 900 mg every 14 days thereafter.

Strength / Dose

Duration of Therapy (Expected)

**Formulary Alternatives
Attempted/Outcome**

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? **Y** **N**
Pharmacy Phone Number

Practitioner Signature

Date Received: _____
Reviewed By: _____
Forwarded To: _____

**FAX Form to
877-800-5633**