WELLPARTNER PHARMACY | SOLIRIS ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / /

Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

Type of therapy: ◯ New ◯ Continuing ◯ Restart

◯ D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)

◯ D59.3 Hemolytic-uremic syndrome

◯ Other:

Height (in/cm): Weight (lb/kg):

Has patient received meningococcal vaccination? ◯ Yes ◯ No

If no, reason:

Infusion appointment day: / / Time:

Allergies:

Current Medications:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Soliris	300 mg/30 ml vial (10 mg/ml)	◯ For treatment of PNH: ◯ Dose titration - Month 1: Administer 600 mg via IV infusion every 7 days for 4 weeks ◯ Dose titration to maintenance - Month 2: Administer 900 mg via IV infusion every 2 weeks starting on week 5 ◯ Maintenance dosing: Administer 900 mg vial IV infusion every 2 weeks ◯ Other:	◯ 4-week supply ◯ 12-week supply ◯	
		◯ For treatment of aHUS - 18 years or older ◯ Dose titration - Month 1: Administer 900 mg via IV infusion every 7 days for 4 weeks ◯ Dose titration to maintenance - Month 2: Administer 1200 mg via IV infusion every 2 weeks starting on week 5 ◯ Maintenance dosing: Administer 1200 mg vial IV infusion every 2 weeks ◯ Other:	◯ 4-week supply ◯ 12-week supply ◯	

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE