TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

SOLIRIS®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

CLINICAL INFORMATION

Primary ICD-10 Code (Please Specify Diagnosis): _____

Secondary ICD-10 Code (Please Specify Diagnosis): _____

MG-ADL* score: _____ Has the patient received Meningitis vaccination(s)? ☐ Yes ☐ No Date of vaccination(s): _____

☐ Please check this box if the patient has declined vaccination Reason: _____

Adverse reactions with previous Soliris treatments? ☐ No ☐ Yes *If yes*, Reason/Date: _____

☐ Please check to confirm: The patient is enrolled in the SOLIRIS REMS program; The patient has been counseled about the risks of meningococcal infection; The patient has received information and a Patient Safety Card about the symptoms and risks of meningococcal infection.

SOLIRIS® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Strength	Dose/Frequency	Refills
☐ Soliris® (eculizumab)	☐ 300mg/30mL	☐ Loading dose: _____mg IV every _____ weeks for weeks. ☐ Maintenance dose: _____mg IV every _____ weeks. ☐ Other: _____	_____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.