Soliris Order

Phone: (346) 708-5160
Fax: (888) 963-8103
www.biotekrx.com

PATIENT INFORMATION (Complete or fax existing chart)			PRESCRIBER INFORMATION	
Patient Name:			Prescriber Name:	
Address:			State License:	NPI#:
City, State, Zip:			DEA:	Phone:
Phone:	2nd Phone:		Address:	Fax:
DOB:	Gender: ☐ Male ☐ Female		City, State, Zip:	
Weight:	Ht:	Date:	Contact Person:	Phone:
ICD-10 code: Diagnosis:				
Allergies:				
Neisseria Meningitis Vaccination Date:				

INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)			
Primary Insurance:		RX Card (PBM):	
City, State, Zip:		BIN:	PCN:
Plan#	Group#	City, State, Zip:	
Phone:		Plan#	Group#

PRESCRIPTION / ADMINISTRATION

Medication	Dose	Directions	Refills
Induction Dosing	☐ 600 mg IV ☐ 900 mg IV ☐ 1200 mg IV	Weekly for the first 4 weeks	3
Transition Dosing	☐ 900 mg IV ☐ 1200 mg IV	Fifth dose 1 week after induction dosing	0
Maintenance Dosing	☐ 900 mg IV ☐ 1200 mg IV	Every 2 weeks following transition dosing	

SIGNATURE

× _____ Date: _____

Product Substitution Permitted

Fax completed form to: (888) 963-8103 - Thank you for using BioTek reMEDys®