



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:	2 nd Phone:	Address:	Fax:
DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	City, State, Zip:	
Weight:	Ht:	Date:	Contact Person:
ICD-10 code: Diagnosis:		Phone:	
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	<input type="checkbox"/> 600 mg IV <input type="checkbox"/> 900 mg IV <input type="checkbox"/> 1200 mg IV	Weekly for the first 4 weeks	3
Transition Dosing	<input type="checkbox"/> 900 mg IV <input type="checkbox"/> 1200 mg IV	Fifth dose 1 week after induction dosing	0
Maintenance Dosing	<input type="checkbox"/> 900 mg IV <input type="checkbox"/> 1200 mg IV	Every 2 weeks following transition dosing	
SIGNATURE			
x _____ Date: _____ Product Substitution Permitted			

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