



Soliris Order

Phone: (877)-246-9104

Fax: (800) 783-9146

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			

CONFIDENTIALITY STATEMENT: This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited.

If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form to: (800) 783-9146 - Thank you for using BioTek reMEDys®