

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		2. PRESCRIBER INFORMATION	
Name:		Name:	
Address:		DEA #:	NPI #: State Lic. #:
City, State, ZIP:		Group or Hospital:	
Primary Phone: - -	DOB: / /	Address:	
Alternate Phone: - -	Gender:	City, State, Zip:	
Email:		Phone: - -	Fax: - -
Primary Language:	Last Four of SSN:	Contact Person: Phone: - -	

3. INSURANCE INFORMATION		<i>Fax copy of prescription and insurance cards with this form, if available (front and back)</i>	
Primary Insurance Company Name:		Secondary Insurance Company Name:	
Primary Cardholder Name:		Secondary Cardholder Name:	
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent		Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	
Phone: - -	Member ID: Group #:	Phone: - -	Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION	
Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
Date of Diagnosis: / /	Type of therapy: <input type="radio"/> New <input type="radio"/> Continuing <input type="radio"/> Restart
<input type="radio"/> D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)	Has patient received meningococcal vaccination? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> D59.3 Hemolytic-uremic syndrome	If no, reason:
<input type="radio"/> Other:	Infusion appointment day: / / Time:
Height (in/cm): Weight (lb/kg):	Allergies:
	Current Medications:

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

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

6. PRESCRIBER SIGNATURE	
X _____ / /	X _____ / /
DISPENSE AS WRITTEN	PRODUCT SUBSTITUTION PERMITTED
DATE	DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.