Clearwater: Phone: & Fax: 727.977.9717 Tampa: Phone & Fax: 813.775.9997 Sarasota: Phone & Fax: 941-413-3280 Ft. Myers: Phone & Fax: 239-533-5962 Orlando: Phone & Fax: 407-792-6558

Email: intake@sageinfusion.com I Online: www.sageinfusion.com



Soliris Infusion Order

Patient Name:	DOB:	☐ Male ☐ Female
Diagnosis (please provide ICD10 code)		
Other:		
□ NKDA Allergies:		
□ New Start Therapy □ Continuation	of Therapy Date of last dose (if ap	plicable):
Ordering Provider:		
Provider NPI:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:
PRE-MEDICATION	REQUI	RED LABS
☐ Acetaminophen1000mg PO ☐ Solu-Medro ☐ Diphenhydramine 25mg PO ☐ Solu-Cortef	ol 125mg IVP serogr i 100mg IVP infusio	gococcal vaccination (both conjugate and oup B) are required prior to initiating Solirisons (please attach documentation).
☐ Ceterizine 10mg PO ☐ Diphenhydr SOLIRIS ORDERS	ramine 25mg IVP 🗹 Date o	f meningococcal vaccine:
 Induction Dose (Choose one. If patient has alreaded by the first four weels fifth dose one week later, then 900md weekly for the first four weels fifth dose one week later, then 1200 Maintenance Dose (Choose one)	ks followed by 900mg for the ng two weeks later ks followed by 1200mg for the mg two weeks later on of 5mg/ml olume 180ml, 1200mg doses final volume 24 ption will expire one year from date	40ml) e signed)
Provider Name	·	
Provider Signature		Date

Monitor the patient for at least one hour following completion of the infusion for signs or symptoms of an infusion reaction.