BIOCURE

Phone: 713-360-2100 or 1-855-497-7956
Fax: 713-244-5120 or 1-844-486-2186

Date: _____

Enrollment Form
Statement of Medical Necessity
Soliris
NMOSD and Myasthenia Gravis

Patient Information

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ Gender: ☐ Male ☐ Female
Height: _____ Weight: _____ Weight Date: _____
Phone: _____ Cell: _____

Patient Records (Please Attach and Fax):
1. Insurance Card(s) and Demographic Information
2. Recent Clinical Assessment Note or H&P
3. Current Medication List
4. Diagnostics Tests

Allergies: _____

☐ **NKDA** ☐ **Initiate Appeal Reason:** _____

Statement of Medical Necessity - Primary Diagnosis

ICD-10: ☐ **generalized Myasthenia Gravis (gMG) G70.0**
☐ **NMOSD - G36.0**

☐ **Anti-acetylcholine receptor (AChR) positive? Yes ☐ No ☐**
☐ **Anti-aquaporin antibody positive? Yes ☐ No ☐**

Indicate tried and failed therapies / contraindications / intolerances to any of the following:

☐ immunosuppressants, such as glucocorticoids, azathioprine, cyclosporine, mycophenolate, methotrexate, tacrolimus
☐ chronic plasmapheresis or plasma exchange ☐ intravenous immune globulin (IVIG)

Prescription and Orders

Is this the first dose? ☐ Yes ☐ No If No, date first dose given: _____

Target Start Date: _____ Next MD Appointment: _____

Prescriber **must** be enrolled in REMS program. For enrollment, go to **www.SolirisREMS.com**

Patient received meningococcal vaccination(s) on ____/____/_____

☐ **Initial:** Mix Soliris 900 mg/90 mL in NS 90 mL
Infuse 900 mg/180 mL IV via gravity/pump once a week x 4 infusions

☐ **Maintenance:** Mix Soliris 1200 mg/120 mL in NS 120 mL
Infuse 1200 mg/240 mL IV via gravity/pump every 2 weeks, starting on week 5

Dispense: 4 week supply May refill: _____

Access: ☐ Peripheral ☐ PICC ☐ Port Other: _____

Biocure Flushing Protocol is the following:

NS Flushes (10mL) #QS:
PIV: 3mL to 5mL IV pre/post + prn.
PAC: 10mL IV pre/post + prn

Adult: Heparin 100 units/mL (5mL) #QS:
PIV: None
PAC: 5mL IV Post

Adverse/Anaphylactic Reactions: Anaphylaxis kit will be provided containing one of each of the following:

Diphenhydramine 25 mg capsules and 50 mg/mL 1mL, vial Epinephrine 1:1000 (1mg/mL) syringe, 0.9% NaCl 500 mL bag,
SIG: U.D. prn anaphylaxis

Prescriber Information

Prescriber Name: _____ **Office Contact (required):** _____

Address: _____ **License:** _____

City: _____ State: _____ Zip: _____ **DEA:** _____

Phone: _____ Fax: _____ NPI: _____

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing BioCure LLC and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-pay Assistance Foundations

Prescriber Signature: _____ Date: _____

[No Stamped Signatures Allowed]