reliance|rx℠
45 Earhart Drive, Suite 110, Amherst, NY 14221

SOLIRIS® AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name First Name	Today's Date Date Needed
Parent/Guardian	Prescriber Hospital/Clinic
Home Phone Number ( ) Work Phone Number ( )	Phone Number ( ) Fax Number ( )
Home Address City State Zip	Address City State Zip
Ship To: ☐ Prescriber ☐ Patient's Home	Office Contact Prescriber Speciality
Language Preference ☐ English ☐ Spanish ☐ Other	
Known Allergies:	Contact Preference ☐ Phone ☐ Fax ☐ Email: _____
Weight _____ Lbs. Height ____ Ft ____ In Date of Birth ____ / ___ / ___ Sex ☐ M ☐ F	Special Instructions

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: _____
Name of Insured: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____

Secondary Insurance: _____
Name of Insured: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD9 Code: _____

☐ Submission of documentation that patient received a meningococcal vaccine at least two weeks prior to initiation of Soliris® therapy and revaccination according to current medical guidelines for vaccine use is scheduled.

☐ Soliris® is administered in the physician's office or infusion center only.

☐ Place of administration must have appropriate staff, equipment and medications to treat infusion-related reactions including epinephrine, diphenhydramine, corticosteroids, and oxygen, AND

☐ Submission of baseline serum LDH level.

☐ Submission of baseline free hemoglobin level.

DRUG NAME: SOLIRIS®

☐ New Authorization ☐ Re-authorization*

Dose: _____

Frequency: _____