

PATIENT INFORMATION

Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

- Diagnosis: Paroxysmal nocturnal hemoglobinuria (PNH) ICD-10 Code: _____
- Atypical hemolytic uremic syndrome (aHUS) ICD-10 Code: _____
- Myasthenia Gravis (gMG) with AChR antibody positive ICD-10 Code: _____
gMG Classification: II III IV
- Neuromyelitis Optica Spectrum disorders (NMOSD) ICD-10 Code: _____

Patient Weight: _____ lbs. Allergies: _____

- Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis and including past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy.
- Positive serologic test for anti-aquaporin antibodies (if NMOSD diagnosis)
- Positive serologic test for anti-AChR antibodies (if Myasthenia Gravis diagnosis)

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

SOLIRIS ORDERS

Adult Dosing:

- PNH (Initial Dose)
600mg IV weekly for the first 4 weeks, followed by 900mg IV for the fifth dose 1 week later, then 900mg IV every 2 weeks thereafter
 Maintenance Dose: 900mg IV every 2 weeks
- aHUS, gMG, and NMOSD (Initial Dose)
900mg IV weekly for the first 4 weeks, followed by 1200mg IV for the fifth dose 1 week later, then 1200mg IV every 2 weeks thereafter
 Maintenance Dose: 1200mg IV every 2 weeks

Required:

- Yes No - Patient has had the meningococcal vaccines (both MenACWY and MenB)
- Yes No - Prescriber is enrolled in Soliris REMS Program

Optional: Patient may enroll in One Source by calling (888) 765-4747

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____
Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

- Alpharetta, GA Arlington, TX Atlanta, GA Austin, TX Bee Cave, TX Birmingham, AL Cape Coral, FL Clear Lake, TX Clearwater, FL Coppell, TX Creve Coeur, MO Dallas, TX
 Decatur, GA Denver, CO El Paso East, TX El Paso West, TX Fort Myers, FL Fort Worth, TX Hendersonville, TN Houston, TX Huntsville, AL Independence, MI Kansas City, MI
 Knoxville, TN Kyle, TX Lubbock, TX Montgomery, AL Murfreesboro, TN Naples, FL Nashville, TN North Hills, TX Plano, TX Round Rock, TX San Antonio, TX Sarasota, FL
 Smyrna, GA St. Louis, MI Stone Oak, TX Waco, TX West Houston, TX The Woodlands, TX Other: _____