

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: New to Therapy Continuing Therapy **Next Treatment Date:** _____**MEDICAL INFORMATION**

- Diagnosis:**
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- Paroxysmal nocturnal hemoglobinuria (PNH) (ICD-10 Code: D59.5)
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- Atypical hemolytic uremic syndrome (aHUS) (ICD-10 Code: D59.3)
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- Myasthenia Gravis (gMG) w/out acute exacerbation (ICD-10 Code: G70.00)
-
- gMG Classification:
-
- II
-
- III
-
- IV
-
-
- Neuromyelitis Optica Spectrum disorders (NMOSD) (ICD-10 Code: G36.0)
-
-
- Other: _____ (ICD-10 Code: _____)

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER**Soliris Adult Dosing:****PNH Diagnosis-**

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- Initial Start: 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 x 1 year
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- Maintenance Dose: 900mg IV every 2 weeks x 1 year

aHUS, gMG, and NMOSD Diagnosis-

-
- Initial Start: 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 x 1 year
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-
- Maintenance Dose: 1200mg IV every 2 weeks x 1 year

Lab orders: _____ **Frequency:** _____Required labs to be drawn by: Paragon Referring Provider**Other orders:** _____**Anaphylactic Reaction Orders:**

- Epinephrine (based on patient weight)
 - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
 - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN**PROVIDER 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, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

 Opt out of Paragon selecting site of care (if checked, please list site of care): _____**PREFERRED LOCATION**

City: _____ State: _____

View our locations here:



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REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Prescriber enrolled in REMS
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) to support primary diagnosis including past tried and failed therapies, intolerance, outcomes, or contraindications to conventional therapy
 - MG-ADL score (gMG diagnosis): _____
 - Previous or current therapies: _____
 - aHUS - The following have been ruled out in patients with aHUS:
 - Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS) Yes No
 - Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency) Yes No
- Labs attached
 - AchR antibody (gMG diagnosis)
 - AQP4 antibody (NMOSD diagnosis)
 - CBC and CMP (aHUS diagnosis)
- Diagnostic testing to support diagnosis
 - Flow Cytometry Test (PNH diagnosis)
 - Abnormal Neuromuscular Transmission test (i.e., SFEMG) (MG diagnosis)
 - CBC and CMP (aHUS and PNH diagnosis)
- Is the patient enrolled in OneSource? Yes No
Patient may enroll in One Source by calling (888) 765-4747
- Other medical necessity: _____

REQUIRED PRE-SCREENING

- Has the patient had both meningococcal vaccines (MenACWY and Men B)?** Yes No
- Attach proof of meningococcal vaccines - both vaccines are required prior to therapy**

ParagonHealthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance

PARAGONHEALTHCARE.COM

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