PARAGON HEALTHCARE

NEUROLOGY INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

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:** _____

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back)

MEDICAL INFORMATION

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

THERAPY ORDER

Diagnosis	Infusion Orders
☐ Alzheimer's Disease ICD-10: _____	Administer **Aduhelm** IV every 4 weeks as follows (select one): ☐ **Initial start** w/ maintenance dosing: 1mg/kg for infusion 1 and 2, 3mg/kg for infusion 3 and 4, 6mg/kg for infusion 5 and 6, then 10mg/kg for infusion 7 and beyond x1 year ☐ **Maintenance dosing** only: 10mg/kg IV every 4 weeks x1 year
☐ Acute Migraines ICD-10: _____	**Premedication:** ☐ Zofran 4mg IVP ☐ Zofran 8mg IVP ☐ Pepcid IV 20mg IVP ☐ Toradol 30mg IVP ☐ Solu-Medrol 125mg IVP ☐ Reglan 10mg IV/100mL NS over 20 minutes ☐ Benadryl 25mg IV **Protocol:** ☐ Depacon ☐ 500mg ☐ 750mg IV in 250mL NS ☐ Magnesium Sulfate 1gm IV in 250mL ☐ DHE 45 ☐ 0.5mg ☐ 1mg IV in 100mL NS *(must premed for nausea)* **Standing PRN Order**: ☐ 1 month ☐ 2 months ☐ 3 months Repeat regimen daily for _____ days/wk
☐ Migraines ICD-10: _____	**Vyepti**: ☐ 100mg IV every 3 months x1 year ☐ 300mg IV every 3 months x1 year
☐ Multiple Sclerosis Exacerbation ☐ Other: _____ ICD-10: _____	☐ Solu-Medrol 1gm IV daily x _____ days OR ☐ Solu-Cortef 1gm IV daily x _____ days
☐ Diagnosis: _____ ICD-10: _____	**Soliris**: *(neuro dosing)* ☐ 900mg IV weekly for the first 4 weeks, followed by 1200mg for the fifth dose 1 week later, then 1200mg every 2 weeks thereafter x1 year (inital start with maintenance) ☐ 1200mg IV every 2 weeks x1 year (maintenance dosing)
☐ Multiple Sclerosis ICD-10: _____	☐ **Tysabri** 300mg IV every 4 weeks (after registering patient with TOUCH) Premedication protocol: Tylenol 1000mg PO and Benadryl 25mg PO ☐ **Ocrevus** ☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x1 year ☐ 600mg IV every 6 months x1 year Premedication Protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO to be given 30 minutes before infusion
☐ Diagnosis: _____ ICD-10: _____	**IVIg** Orders: _____ mg/kg **OR** _____ gm/kg IV divided over _____ day(s) **Frequency:** Every _____ weeks x1 year **OR** _____ one time dose only **Protocol Pre-Medication Orders:** Tylenol 1000mg PO *please choose one antihistamine:* ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO **Additional Pre-Medication Orders:** ☐ Solu-Medrol _____ mg IVP ☐ Other:_____ Preferred brand: _____ (Paragon to choose if not indicated)
☐ Diagnosis: Myasthenia Gravis ICD-10: _____	**Ultomiris**: *(neuro dosing)* Loading dose: ☐ 2,400mg ☐ 2,700mg ☐ 3,000mg IV followed 2 weeks later by Maintenance dose of: ☐ 3,000mg ☐ 3,300mg ☐ 3,600mg IV every 8 weeks x1 year

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):

SERVICE AREAS

☐ Atlanta ☐ Austin ☐ Birmingham ☐ Dallas/Fort Worth ☐ Denham Springs ☐ Denver ☐ East Texas
☐ Houston ☐ Huntsville ☐ Kansas City ☐ Knoxville ☐ Montgomery ☐ Nashville ☐ Oklahoma City
☐ Orlando ☐ San Antonio ☐ St. Louis ☐ Tampa ☐ West Texas

PARAGON HEALTHCARE

COMPREHENSIVE SUPPORT FOR NEUROLOGY THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to support primary diagnosis
  - ☐ MRI documentation (Tysabri, Aduhelm, and Ocrevus)
  - ☐ Hepatitis B antigen and Hepatitis B core total (Ocrevus orders)
- ☐ Labs attached
  - ☐ JCV antibody (Tysabri orders)
  - ☐ Other supporting labs supporting diagnosis/order
- ☐ Diagnostic testing
  - ☐ Confirmed presence of amyloid pathology - CSF or PET scan (Aduhelm orders)
  - ☐ Other diagnostic testing to support diagnosis/order
- ☐ Vaccine record
  - ☐ Meningococcal vaccinations - both Men B and Men ACWY (Soliris & Ultomiris orders)
- ☐ Other medical necessity: _____

Paragon Healthcare 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