

PATIENT INFORMATION Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

Allergies:

Diagnosis Code ICD-10: (required)	Diagnosis Description:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Treatment Date:

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:		Email:	
Address:		City:	State: ZIP:
NPI #:	DEA#:	Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Medication Orders	
<input type="checkbox"/> Lumizyme 20mg/kg IV every 2 weeks x1 year <input type="checkbox"/> Nexviazyme 20mg/kg IV every 2 weeks x1 year	
Vyepti: <input type="checkbox"/> 100mg IV every 3 months x1 year OR <input type="checkbox"/> 300mg IV every 3 months x1 year	
<input type="checkbox"/> Solu-Medrol 1gm IV daily x _____ day(s) OR <input type="checkbox"/> Solu-Cortef 1gm IV daily x _____ day(s)	
Soliris: <input type="checkbox"/> 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 (initial start with maintenance) <input type="checkbox"/> 1200mg IV every 2 weeks x1 year (maintenance dosing)	
<input type="checkbox"/> Tysabri 300mg IV every 4 weeks x1 year (after registering patient with TOUCH) <input type="checkbox"/> Ocrevus* <input type="checkbox"/> 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x1 year <input type="checkbox"/> 600mg IV every 6 months x1 year <input type="checkbox"/> Ocrevus Zunovo 920mg/23,000units subcutaneously every 6 months x1 year Premed protocol: dexamethasone 20mg PO & cetirizine 10mg PO 30 minutes prior to Ocrevus Zunovo <input type="checkbox"/> Briumvi* <input type="checkbox"/> 150mg IV x1, then 450mg IV 2 weeks later, followed by 450mg IV every 24 weeks x1 year <input type="checkbox"/> 450mg IV every 24 weeks x1 year *Premed Protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO/IV to be given 30 minutes before infusion	
IVlg Orders: _____ mg/kg OR _____ gm/kg IV divided over _____ day(s) Frequency: Every _____ weeks x1 year OR _____ one time dose only Preferred brand: _____ (Paragon to choose if not indicated)	
Ultomiris: Loading dose: <input type="checkbox"/> 2,400mg (40-59kg) <input type="checkbox"/> 2,700mg (60-99kg) <input type="checkbox"/> 3,000mg (100kg+) (neuro dosing) IV followed 2 weeks later by Maintenance dose of: <input type="checkbox"/> 3,000mg (40-59kg) <input type="checkbox"/> 3,300mg (60-99kg) <input type="checkbox"/> 3,600mg IV (100kg+) IV every 8 weeks x1 year	
Vyvgart: <input type="checkbox"/> 10mg/kg IV once weekly for 4 weeks (<120kg) <input type="checkbox"/> 1200mg IV over 1 hour once weekly for 4 weeks (≥120kg)	<input type="checkbox"/> _____ refill(s), cycles to have _____ weeks between infusion cycles (4 weekly infusions = 1 treatment cycle)
Vyvgart Hytrulo: <input type="checkbox"/> 1,008 mg / 11,200 units subcutaneously Frequency: <input type="checkbox"/> weekly for 4 weeks OR <input type="checkbox"/> every week	<input type="checkbox"/> _____ refill(s)
Rystiggo*: <input type="checkbox"/> <50kg: 420mg <input type="checkbox"/> 50kg to <100kg: 560mg <input type="checkbox"/> ≥100kg: 840mg subQ weekly x6 *Cycle may be repeated ≥63 days from start of previous cycle. Subsequent cycles may be ordered as appropriate	<input type="checkbox"/> _____ refill(s), cycles to have _____ weeks between infusion cycles (6 weekly infusions = 1 treatment cycle)
Imaavy: <input type="checkbox"/> Initial start: 30mg/kg IV x1, then 15mg/kg IV 2 weeks later, then 15mg/kg IV every 2 weeks thereafter x 1 year <input type="checkbox"/> Maintenance dose: 15mg/kg IV every 2 weeks x 1 year	
<input type="checkbox"/> Amvuttra 25mg SubQ every 3 months x1 year	
Premedication orders: Tylenol <input type="checkbox"/> 1000mg <input type="checkbox"/> 500mg PO, please choose one antihistamine (if required): <input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Cetirizine 10mg IVP	
Additional premedications: <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP <input type="checkbox"/> Other _____	
Lab orders: _____ Frequency: <input type="checkbox"/> Every infusion <input type="checkbox"/> Other: _____	

 As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PRESCRIBER SIGNATURE 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.

Prescriber Signature: X	Date:
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PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's current medication list
- Supporting clinical notes (H&P) to support primary diagnosis - Including tried/failed therapies, intolerance, benefits, of contraindications to conventional therapy
 - Has the patient tried and failed previous drug therapy?
If yes, which drug(s)? _____
- Labs attached
 - JCV antibody (Tysabri orders)
 - AChR antibody or MuSK antibody (Rystiggo, Imaavy, Vyvgart & Ultomiris)
 - Hepatitis B antigen and Hepatitis B core total antibody (Ocrevus & Briumvi)
 - Serum immunoglobulins (Ocrevus & Briumvi)
 - Other supporting labs based on diagnosis/order
- Diagnostic testing
 - MRI documentation (Tysabri, Ocrevus, Briumvi)
 - Other diagnostic testing to support diagnosis/order
- Vaccine record
 - Meningococcal vaccinations - both Men B and Men ACWY (Soliris & Ultomiris orders)
- Other medical necessity: _____