PARAGON HEALTHCARE

A Carelon Company

NEUROLOGY ORDER SET

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

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

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ 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)

Drug	Dosing	Refills
Amvuttra	☐ 25mg SubQ every 3 months	☐ x1 year ☐ _____
Briumvi	☐ 150mg IV x1, then 450mg IV 2 weeks later, followed by 450mg IV every 24 weeks ☐ 450mg IV every 24 weeks x1 year **Pre-med Protocol**: Solu-Medrol 100mg IV and diphenhydramine 25mg PO/IV 30 minutes before infusion	☐ x1 year ☐ _____
Imaavy	☐ 30mg/kg IV x1, then 15mg/kg IV 2 weeks later, then 15mg/kg IV every 2 weeks thereafter ☐ 15mg/kg IV every 2 weeks	☐ x1 year ☐ _____
IVIg	Orders: _____ mg/kg **OR** _____ gm/kg IV divided over _____ day(s) **Frequency:** Every _____ weeks **OR** _____ one time dose only Preferred brand: _____ (Paragon to choose if not indicated)	☐ x1 year ☐ _____
Nexviazyme	☐ 20mg/kg IV every 2 weeks	☐ x1 year ☐ _____
Ocrevus	☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months ☐ 600mg IV every 6 months **Pre-med Protocol**: Solu-Medrol 100mg IV and diphenhydramine 25mg PO/IV 30 minutes before infusion	☐ x1 year ☐ _____
Ocrevus Zunovo	☐ 920mg/23,000units subcutaneously every 6 months **Pre-med protocol**: dexamethasone 20mg PO & cetirizine 10mg PO 30 minutes prior	☐ x1 year ☐ _____
Rystiggo*	☐ <50kg: 420mg ☐ 50kg to <100kg: 560mg ☐ ≥100kg: 840mg subQ weekly x6 *Cycle may be repeated ≥63 days from start of previous cycle. Subsequent cycles may be ordered as appropriate	☐_____ refill(s), cycles to have _____ weeks between infusion cycles (6 weekly infusions = 1 treatment cycle)
Solu-Medrol	1gm IV daily x _____day(s)	None
Soliris	☐ 900mg IV weekly for the first 4 weeks, followed by 1200mg for the fifth dose 1 week later, then 1200mg every 2 weeks thereafter ☐ 1200mg IV every 2 weeks	☐ x1 year ☐ _____
Tysabri	☐ 300mg IV every 4 weeks	☐ x1 year ☐ _____
Ultomiris	Loading dose: ☐ 2,400mg (40-59kg) ☐ 2,700mg (60-99kg) ☐ 3,000mg (100kg+) IV followed 2 weeks later by a maintenance dose of: ☐ 3,000mg (40-59kg) ☐ 3,300mg (60-99kg) ☐ 3,600mg IV (100kg+) IV every 8 weeks	☐ x1 year ☐ _____
Vyepti	☐ 100mg IV every 3 months OR ☐ 300mg IV every 3 months	☐ x1 year ☐ _____
Vyvgart	☐ 10mg/kg IV once weekly for 4 weeks (<120kg) ☐ 1200mg IV once weekly for 4 weeks (≥120kg)	☐_____ refill(s), cycles to have _____ weeks between infusion cycles (4 weekly infusions = 1 treatment cycle) ☐_____ refill(s) ☐ None
Vyvgart Hytrulo	☐ 1,008 mg / 11,200 units subcutaneously Frequency: ☐ weekly for 4 weeks ☐ every week	

Pre-medication orders: Acetaminophen ☐ 1000mg ☐ 500mg PO, please choose one antihistamine (if required):
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Cetirizine 10mg IVP
Additional pre-medications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other _____
Lab orders: _____ **Lab Frequency:** _____

As required by your state, Prescriber to check "Dispense as written" or handwrite "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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COMPREHENSIVE SUPPORT FOR NEUROLOGY THERAPY

PATIENT INFORMATION

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 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

☐ Meningococcal vaccinations - both Men B and Men ACWY (Soliris & Ultomiris)

☐ Other medical necessity: _____