



A Carelon Company

SOLIRIS (ECULIZUMAB) INFUSION ORDERS

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: <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)

Drug	Dosing	Refills
Soliris (eculizumab)	<input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 900mg IV every 2 weeks <input type="checkbox"/> 1200mg IV every 2 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____

Required labs to be drawn by: Paragon Referring Provider

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:
--------------------------------	--------------

PATIENT INFORMATION

Name:

DOB:

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**