PARAGON
INFUSION CENTERS

SOLIRIS (ECULIZUMAB) INFUSION ORDERS

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ____________________ DOB: __________ Phone: ____________________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Diagnosis:
☐ Paroxysmal nocturnal hemoglobinuria (PNH). ICD-10 Code: __________
☐ Atypical hemolytic uremic syndrome (aHUS) ICD-10 Code: __________
☐ Myasthenia Gravis (gMG) with AChR antibody positive ICD-10 Code: __________
gMG Classification: ☐ II ☐ III ☐ IV
☐ Neuromyelitis Optica Spectrum disorders (NMOSD) ICD-10 Code: __________

Patient Weight: __________ lbs. Allergies: ______________________________

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis and including past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy.
☐ Positive serologic test for anti-aquaporin antibodies (if NMOSD diagnosis)
☐ Positive serologic test for anti-AChR antibodies (if Myasthenia Gravis diagnosis)

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ______________________________

SOLIRIS ORDERS

Adult Dosing:

☐ PNH (Initial Dose)
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
☐ Maintenance Dose: 900mg IV every 2 weeks

☐ aHUS, gMG, and NMOSD
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
☐ Maintenance Dose: 1200mg IV every 2 weeks

Required:
☐ Yes ☐ No - Patient has had the meningococcal vaccines (both MenACWY and MenB)
☐ Yes ☐ No - Prescriber is enrolled in Soliris REMS Program

Optional: Patient may enroll in One Source by calling (888)765-4747

Additional Orders/Comments:

PHYSICIAN 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.

Physician Signature: ______________________________ Date: __________

Physician Name: ______________________________

Phone: __________ Fax: __________ Contact Person: ____________________

INFUSION CENTER LOCATIONS

	Texas	Tennessee	Georgia
Phone: 877-365-5566 **Fax: 855-889-2946**	☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	☐ Knoxville	☐ Atlanta

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