

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 866.388.1488

Patient Name: _____ DOB: _____ Phone: _____

ICD-10 code (required): _____ ICD-10 description: _____

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) Height: _____ Diabetic Yes No

Allergies: _____

 First Dose: Yes No Date of Last Infusion: _____ Brand Used: _____

Lab Orders: _____

Labs: Required labs to be drawn by Paragon Healthcare Referring Provider

THERAPY ORDER
Ig Orders: IV Sub Q _____ gm/kg IV divided over _____ day(s) **OR** _____ mg/kg IV divided over _____ day(s)

Frequency: Repeat dose every _____ weeks for 1 year

 Repeat dose every _____ weeks for _____ weeks total

- Pharmacist to identify clinically appropriate Ig brand and infusion rates. May substitute based on product availability.
- Infuse entire contents of Ig infusion bag/vial(s) per current dose.
- If needed, round dose to nearest whole 5 gm vial for IV doses and nearest single-use vial size for subQ doses.

Pre-Medication Orders: *to be administered 15-30 minutes before infusion*
 Acetaminophen 500mg PO

 Solu-Medrol _____ mg IVP

 Diphenhydramine 25mg PO

 Other: _____

 Normal Saline 500mL IV

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
 - >30kg (>66lbs): EpiPen® 0.3mg or compounded syringe IM or subQ; may repeat in 3-5 minutes x 1
 - 15-30kg (33-66lbs): EpiPen® 0.15mg or compounded syringe IM or subQ; may repeat in 3-5 minutes x 1
- Diphenhydramine - Administer 25-50mg orally OR IV
- NS 500 mL IV bolus as needed for IVIg therapy

PROVIDER INFORMATION Orders are good for one year from the signature date

 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): _____

***FOR PARAGON USE ONLY**

Drug/Brand Selection: _____ Date: _____

NP/Pharmacist Name: _____ NP/Pharmacist Signature: _____

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

REQUIRED DOCUMENTATION FOR INSURANCE APPROVAL
GENERAL REQUIREMENTS

- Patient demographics
- Insurance information
- All applicable diagnoses
- History and physical
- Recent progress notes within 12 months
- Patient's height and weight
- Drug allergies
- Physician Orders
- Plus one of the following

**COMMON VARIABLE IMMUNODEFICIENCY (CVID) /
HYPOGAMMAGLOBULINEMIA / PARKINSON'S DISEASE (PD)**

- Lab last showing Ig levels and subclasses Ig levels.
- Documentation of recurrent infections
- History of antibiotic usage - showing failure to respond to antibiotics
- Documented inadequate response to pneumococcal vaccine or tetanus/diphtheria

**CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) /
GUILLAIN-BARRÉ SYNDROME (GBS)**

- Labs
- Nerve conduction study, electromyography (EMG)
- Nerve and/or muscle biopsy (if available)
- Nerve conduction velocity (NCV) test results
- Tried and failed treatments
- Spinal tap (if available)

MYASTHENIA GRAVIS

- Exacerbation
- Any history of crisis
- Thymectomy
- Any symptoms that affect respiration, speech or motor function
- Tried and failed treatments