

**PATIENT INFORMATION**
 *Demographics attached*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Patient Weight: \_\_\_\_\_ lbs. Allergies: \_\_\_\_\_

J Code: J0717

Diagnosis:

- |   |   |
|---|---|
| <input type="checkbox"/> Crohn's Disease (ICD-10 Code: _____ )        | <input type="checkbox"/> Plaque Psoriasis (ICD-10 Code: _____ )                         |
| <input type="checkbox"/> Psoriatic Arthritis (ICD-10 Code: _____ )    | <input type="checkbox"/> Non-radiographic Axial Spondyloarthritis (ICD-10 Code: _____ ) |
| <input type="checkbox"/> Rheumatoid Arthritis (ICD-10 Code: _____ )   |   |
| <input type="checkbox"/> Ankylosing Spondylitis (ICD-10 Code: _____ ) | <input type="checkbox"/> Other: _____   |

 **Required Labs:** TB (QFT or PPD), Hep B surface antigen and Hep B core AB total

 Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

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

**Lab Orders:** \_\_\_\_\_

**CIMZIA ORDERS**
**Crohn's Disease**

- 
- Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks
- 
- Maintenance Dose:
- 
- 400mg subcutaneously every 4 weeks

**RA/Psoriatic Arthritis/Ankylosing Spondylitis/Spondyloarthritis**

- 
- Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks
- 
- Maintenance Dose:
- 
- 200mg subcutaneously every 2 weeks
- 
- 
- 400mg subcutaneously every 4 weeks

**Psoriasis**

- 
- 400mg subcutaneously every 2 weeks
- 
- 
- 200mg every 2 weeks
- 
- 
- 400mg subcutaneously at weeks 0, 2, and 4 followed by 200mg every 2 weeks

**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: \_\_\_\_\_ Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

**INFUSION CENTER LOCATIONS**

- 
- Alpharetta, GA
- 
- Arlington, TX
- 
- Atlanta, GA
- 
- Austin, TX
- 
- Bee Cave, TX
- 
- Birmingham, AL
- 
- Cape Coral, FL
- 
- Clear Lake, TX
- 
- Clearwater, FL
- 
- Coppell, TX
- 
- Creve Coeur, MO
- 
- Dallas, TX
- 
- 
- Decatur, GA
- 
- Denver, CO
- 
- El Paso East, TX
- 
- El Paso West, TX
- 
- Fort Myers, FL
- 
- Fort Worth, TX
- 
- Hendersonville, TN
- 
- Houston, TX
- 
- Huntsville, AL
- 
- Independence, MI
- 
- Kansas City, MI
- 
- 
- Knoxville, TN
- 
- Kyle, TX
- 
- Lubbock, TX
- 
- Montgomery, AL
- 
- Murfreesboro, TN
- 
- Naples, FL
- 
- Nashville, TN
- 
- North Hills, TX
- 
- Plano, TX
- 
- Round Rock, TX
- 
- San Antonio, TX
- 
- Sarasota, FL
- 
- 
- Smyrna, GA
- 
- St. Louis, MI
- 
- Stone Oak, TX
- 
- Waco, TX
- 
- West Houston, TX
- 
- The Woodlands, TX
- 
- Other: \_\_\_\_\_

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