

PATIENT INFORMATION
 Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

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

 J Code: J3380 Diagnosis: Crohn's Disease ICD-10 Code: _____

 Ulcerative Colitis ICD-10 Code: _____

 Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

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

 Date of last TB/CXR: _____ Copy of documentation attached

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

Lab Orders: _____

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. Yearly TB Screening (*optional*)

Required Lab: Baseline Liver Enzymes (within 6 months, preferably)

ENTYVIO ORDERS
Entyvio Initial Dosing: 300mg IV at 0, 2, 6 then every 8 weeks

 Maintenance: 300mg IV every 8 weeks

 300mg IV every _____ weeks

****Date of Last:** Remicade Humira Stelara Other: _____ Dose: _____

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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