PARAGON INFUSION CENTERS

GASTROENTEROLOGY ORDER FORM

P: 877.365.5566 | F: 855.889.2946

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: _____

Diagnosis Date: _____ ICD-10: _____ ****Date of last:** ☐ Orencia ☐ Remicade ☐ Humira ☐ Enbrel dose: _____

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

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

Lab Orders: _____

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required (Cimzia, Infliximab)

Hep B Labs: ☐ Hep B antigen attached ☐ Hep B Core antibody total attached ☐ Draw Hep B Labs

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD (Cimzia, Infliximab, Stelara, and Entyvio)

TB test: ☐ TB Test Attached ☐ Perform TB testing

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐ Dehydration ☐ Gastroenteritis ☐ Diverticulitis	☐ 1 Liter ☐ 2 Liters D5 .45% NS IV x 1 day ☐ 1 Liter ☐ 2 Liters NS IV x 1 day ☐ **Cipro** 400mg IV daily x 1 day ☐ **Flagyl** 500mg IV daily x 5 days ☐ **Invanz** 1gm IV daily x 1 day	
☐ Iron Deficiency Anemia ☐ Iron Deficiency Anemia with CKD not on dialysis Required Recent Labs: CBC, Ferritin, Iron Studies	☐ **Venofer** 200mg IV q 3 weeks x 5 doses ☐ **Venofer** 100mg IV q week x 7 weeks then every other week x 7 weeks (10 doses total) ☐ **Venofer** 200mg IV- Administer 5 doses over a 14 day period ☐ **Venofer** 200mg IV weekly x 5 weeks ☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg *if patient weighing less than 50kg (110lbs)* ☐ **Injectafer** 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg *if patient weighing 50kg (110lbs) or greater*	
☐ Crohn's Disease ☐ Ulcerative Colitis	☐ **Cimzia** 400mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks ☐ **Cimzia** _____ mg Sub-Q every _____ weeks ☐ **Infliximab** Brands available: ☐ Inflectra ☐ Remicade ☐ Renflexis ☐ Avsola Dose: _____ mg/kg Frequency ☐ Every _____ weeks OR ☐ 0, 2, 6 then every 8 weeks Pre-medication Orders ☐ Tylenol 1000mg Antihistamine ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25 mg ☐ Loratadine 10 mg PO Additional Pre-Medication Orders: ☐ Solu Medrol 62.5mg IVP ☐ Solu-Medrol 125mg IVP ☐ Solu-Cortef _____ mg IVP ☐ **Stelara** initial infusion: ☐ <55kg 260mg IV over 1 hour x 1 dose ☐ 55kg to 85kg 390mg IV over 1 hour x 1 dose ☐ >85kg 520 mg IV over 1 hour x 1 dose ☐ **Stelara** maintenance: ☐ 90mg SQ 8 weeks after initial infusion and then every 8 weeks. ☐ **Tysabri** 300mg IV every 4 weeks ☐ JCV antibody ☐ Patient TOUCH authorization ☐ **Entyvio** 300mg IV over 30 minutes at 0, 2, 6 weeks and then Q8 weeks (baseline LFTs) ☐ **Entyvio** 300mg IV every 8 weeks	☐ _____ ☐ x 1 year

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: _____