PARAGON INFUSION CENTERS

NEUROLOGY 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: _____

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

☐ Patient's TOUCH authorization (only for Tysabri orders) ☐ Hepatitis B antigen and Hepatitis B Core total antibody required (only for Ocrevus orders) ☐ Confirmed Presence of amyloid pathology (CSF or PET scan) attached (only for Aduhelm orders)

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

Lab Orders: _____

INFUSION ORDERS

☐ Alzheimer's Disease
ICD-10: _____

Administer Aduhelm IV every 4 weeks as follows (Select One):

☐ Initial start w/ maintenance dosing:
- 1mg/kg for infusion 1 and 2
- 3mg/kg for infusion 3 and 4
- 6mg/kg for infusion 5 and 6
- 10 mg/kg for infusion 7 and beyond

☐ Maintenance doing only: 10mg/kg

☐ Migraines
ICD-10: _____

Pre-Medication: ☐ Zofran 4mg slow IVP ☐ Zofran 8mg IVP ☐ Pepcid IV 20mg IVP ☐ Toradol 30mg IVP ☐ Solu-Medrol 125mg IVP ☐ Reglan 10mg IV/100mL NS over 20 minutes ☐ Benadryl 25mg IV

Protocol: ☐ Depacon ☐ 500mg ☐ 750mg IV in 250mL NS
☐ Magnesium Sulfate 1gm IV in 250mL
☐ DHE 45 ☐ 0.5mg ☐ 1mg IV in 100mL NS *(must premed for nausea)*

Standing PRN Order: ☐ 1 month ☐ 2 months ☐ 3 months Repeat regimen daily for _____ days

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☐ Migraines
ICD-10: _____

Vyepti: ☐ 100mg IV every 3 months
☐ 300mg IV every 3 months

☐ Multiple Sclerosis Exacerbation
ICD-10: _____

☐ Solu-Medrol 1gm IV daily x _____ days
☐ Solu-Cortef 1gm IV daily x _____ days

☐ Multiple Sclerosis
ICD-10: _____

☐ Tysabri 300mg IV every 4 weeks (after registering patient with TOUCH)
Pre-medication protocol: Tylenol 1000mg PO and Benadryl 25mg PO

☐ Ocrevus ☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months ☐ 600mg IV every 6 months
Pre-Medication Protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO to be given 30 minutes before infusion

IVIG

Diagnosis: _____ ICD-10: _____ IVIG Brand: _____

IVIG Orders: _____ mg/kg OR _____ gm/kg IV divided over _____ day(s)

Frequency: Every _____ weeks **OR** _____ one time dose only

Protocol Pre-Medication Orders: Tylenol 1000mg PO

please choose one antihistamine: ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg - IVP

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: _____