PARAGON
INFUSION CENTERS

PULMONARY 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, and Tests supporting primary diagnosis attached

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

Lab Orders: ____

FASENRA INJECTION

☐ **Severe Asthma with Eosinophilic phenotype** (ICD-10 __________)

Fasenra Initial Dose: ☐ 30mg subcutaneously every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter

Fasenra Maintenance Dose: ☐ 30mg subcutaneously every 8 weeks

XOLAIR INJECTION

☐ Allergic Asthma (ICD-10:) __________ ☐ ______________________________________

Xolair Dose: ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg **Frequency**: Subcutaneously every: ☐ 2 weeks or ☐ 4 weeks

History: Positive Skin or RAST Test: ☐ Yes ☐ No Test date: ______________

Pre-Treatment IgE Serum: __________ IU/mL Test date: ______________

** **Date of last Xolair Injection:** ______________ *Note: Patient must have an EpiPen in their possession at every appointment.*

PROLASTIN INJECTION

☐ **Alpha-1 Antitrypsin Deficiency (ICD-10 ____________)** ☐ **Panacinar Emphysema (ICD-10 ______________)**

Prolastin Dose: ☐ 60mg/kg IV weekly **OR** ☐ Other: ______________________________

Premedication: ____

** **Date of last Prolastin Infusion:** ______________

GLASSIA INJECTION

☐ **Alpha-1 Antitrypsin Deficiency (ICD-10 ____________)**

Glassia Dose: ☐ 60mg/kg IV weekly **OR** ☐ Other: ______________________________

** **Date of last Glassia Infusion:** ______________

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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