

PATIENT INFORMATION
 Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

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

 Diagnosis: Gaucher Disease ICD-10 Code: _____

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: _____

VPRIV ORDERS
 Dose: 60U/kg IV administered every two weeks as a 60 minute infusion

 Other: _____ U IV every two weeks as a 60 minute infusion

Pre-Medications (optional):
 Acetaminophen _____ mg PO before infusion

 Diphenhydramine _____ mg PO/IV before infusion

 Solu-medrol _____ mg IV before 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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