

**PATIENT INFORMATION:**

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

 Patient Status:  New to Therapy  Continuing Therapy **Next Treatment Date:** \_\_\_\_\_

**MEDICAL INFORMATION**

Patient Weight: \_\_\_\_\_ lbs. (required) Allergies: \_\_\_\_\_

**THERAPY ORDER**

| Diagnosis   | Infusion Orders   | Refills |
|---|---|---------|
| <input type="checkbox"/> Cellulitis<br><input type="checkbox"/> MRSA<br><input type="checkbox"/> Skin Infection/Abscess<br><b>ICD-10:</b> _____   | <input type="checkbox"/> <b>Cubicin</b> <input type="checkbox"/> 4mg/kg IV <input type="checkbox"/> 6mg/kg IV<br><input type="checkbox"/> Daily for _____ days _____ weeks<br><input type="checkbox"/> <b>Orbactiv</b> 1200mg IV x1 dose<br><input type="checkbox"/> <b>Rocephin</b> <input type="checkbox"/> 1gm IV <input type="checkbox"/> 2gm IV<br><input type="checkbox"/> Daily for _____ days _____ weeks<br><input type="checkbox"/> <b>Dalvance</b><br><input type="checkbox"/> 1000mg IV followed 1 week later by 500mg<br><input type="checkbox"/> 750mg IV followed 1 week later by 375mg (CrCl<30)<br><input type="checkbox"/> 1500mg IV x 1 dose<br><input type="checkbox"/> 1125mg IV x 1 dose (CrCl<30)  |         |
| <input type="checkbox"/> Dermatomyositis<br><input type="checkbox"/> Dermatopolymyositis<br><input type="checkbox"/> Phephigoid/Pemphigus<br><input type="checkbox"/> Other: _____<br><b>ICD-10:</b> _____  | <b>IVig Orders:</b> _____ mg/kg <b>OR</b> _____ gm/kg IV divided over _____ day(s)<br><b>Frequency:</b> Every _____ weeks x1 year <b>OR</b> _____ one time dose only<br>Preferred brand: _____ (Paragon to choose if not indicated)   |         |
| <input type="checkbox"/> CIU <b>ICD-10:</b> _____   | <input type="checkbox"/> <b>Xolair</b> <input type="checkbox"/> 150mg SQ every 4 weeks <input type="checkbox"/> 300mg SQ every 4 weeks<br>Note: Patient must have an EpiPen in their possession on their appointment date   |         |
| <input type="checkbox"/> Pemphigus Vulgaris<br><b>ICD-10:</b> _____   | <input type="checkbox"/> <b>Rituximab or rituximab biosimilar</b> as required by patient's insurance<br><input type="checkbox"/> Do not substitute. Infuse the following rituximab product: _____<br><i>For Paragon use only. Brand: _____</i><br>Initial Dose: <input type="checkbox"/> 1000mg IV at day 0, 15 days<br>Maintenance Dose: <input type="checkbox"/> 500mg IV at month 12 and every 6 months thereafter<br>Other dose: _____<br>Protocol Premedication Orders: Solu-Medrol 100mg IV, Tylenol 1000mg PO, and Benadryl 50mg PO/IV   |         |
| <input type="checkbox"/> Psoriatic Arthritis<br><input type="checkbox"/> Psoriasis<br><input type="checkbox"/> Plaque Psoriasis<br><b>ICD-10:</b> _____   | <input type="checkbox"/> <b>Infliximab or infliximab biosimilar</b> as required by patient's insurance<br><input type="checkbox"/> Do not substitute. Infuse the following infliximab product: _____<br><i>For Paragon use only. Brand: _____</i><br>Dose: _____ mg/kg Frequency: <input type="checkbox"/> Every _____ weeks <b>OR</b> <input type="checkbox"/> 0, 2, 6 then every 8 weeks<br><b>Simponi Aria</b> Initial Dose: <input type="checkbox"/> 2mg/kg IV at weeks 0, 4 and then every 8 weeks<br>Maintenance Dose: <input type="checkbox"/> 2mg/kg IV every 8 weeks<br><b>Stelara</b> <input type="checkbox"/> 45mg SQ initially and 4 weeks later followed by 45mg every 12 weeks ( $\leq 100$ kg)<br><input type="checkbox"/> 90mg SQ initially and 4 weeks later followed by 90mg every 12 weeks ( $>100$ kg)<br>Maintenance Dose: <input type="checkbox"/> 45mg SQ every 12 weeks <b>OR</b> <input type="checkbox"/> 90mg SQ every 12 weeks<br><b>Ilumya</b> Initial Dose: <input type="checkbox"/> 100mg SQ at weeks 0, 4 and every 12 weeks thereafter<br>Maintenance Dose: <input type="checkbox"/> 100mg SQ every 12 weeks<br><b>Cimzia</b> <input type="checkbox"/> 200mg SQ every 2 weeks <input type="checkbox"/> 400mg SQ every 4 weeks <input type="checkbox"/> 400mg SQ every 2 weeks<br><input type="checkbox"/> 400mg SQ at weeks 0, 2, and 4 followed by <input type="checkbox"/> 200mg <input type="checkbox"/> 400mg every 2 weeks |         |
| <b>Premedication orders:</b> Tylenol <input type="checkbox"/> 1000mg <input type="checkbox"/> 500mg PO, please choose one antihistamine:<br><input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Quztytir 10mg IVP |   |         |
| <b>Additional premedications:</b> <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP <input type="checkbox"/> Other _____  |   |         |
| <b>Lab orders:</b> _____ <b>Frequency:</b> <input type="checkbox"/> Every infusion <input type="checkbox"/> Other: _____ <input type="checkbox"/> Yearly TB QFT (optional)  |   |         |

**PROVIDER 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, and to select the preferred site of care for the patient.

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

 Opt out of Paragon selecting site of care (if checked, please list site of care): \_\_\_\_\_

**SERVICE AREAS**
 Atlanta  Austin  Birmingham  Dallas/Fort Worth  Denham Springs  Denver  East Texas  
 Houston  Huntsville  Kansas City  Knoxville  Montgomery  Nashville  Oklahoma City  
 Orlando  San Antonio  St. Louis  Tampa  West Texas

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**REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL**

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., steroids)?  Yes  No  
If yes, which drug(s)? \_\_\_\_\_
  - For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Stelara, Cimzia)?  Yes  No  
If yes, which drug(s)? \_\_\_\_\_
- Include labs and/or test results to support diagnosis
- If applicable* - Last known biological therapy: \_\_\_\_\_ and last date received: \_\_\_\_\_. If patient is switching to biologic therapies, please perform a wash-out period of \_\_\_\_\_ weeks prior to starting ordered biologic therapy.
- Other medical necessity: \_\_\_\_\_

**REQUIRED PRE-SCREENING (BASED ON DRUG THERAPY)**

- TB screening test completed within 12 months - attach results**  
Required for: Cimzia, infliximab, Stelara, Ilumya, Simponi Aria  
 **Positive**  **Negative**
- Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM)** Required for: Cimzia, infliximab, rituximab, Simponi  
 **Positive**  **Negative**
- Baseline creatinine** Required for: IVIG

\*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

**Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance**