

**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	Medication Orders	Refills
<input type="checkbox"/> Dermatomyositis <input type="checkbox"/> Dermatopolymyositis <input type="checkbox"/> Pemphigoid/Pemphigus <input type="checkbox"/> Other: _____ <b>ICD-10:</b> _____	<b>IVIg Orders:</b> _____ mg/kg <b>OR</b> _____ gm/kg IV x _____ day(s) <b>OR</b> divided over _____ day(s) <b>Frequency:</b> Every _____ weeks <b>OR</b> _____ Preferred brand: _____ (Paragon to choose if not indicated) Additional Ig orders: _____	<input type="checkbox"/> x1 year <input type="checkbox"/> _____
<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 Note: Patient must have an EpiPen in their possession on their appointment date	<input type="checkbox"/> x1 year <input type="checkbox"/> _____
<input type="checkbox"/> Pemphigus Vulgaris <b>ICD-10:</b> _____	<input type="checkbox"/> <b>Rituximab or rituximab biosimilar</b> as required by patient's insurance <input type="checkbox"/> Do not substitute. Infuse the following rituximab product: _____ For Paragon use only. Brand: _____ Initial Dose: <input type="checkbox"/> 1000mg IV at day 0, 15 days Maintenance Dose: <input type="checkbox"/> 500mg IV at month 12 and every 6 months thereafter Other dose: _____ Protocol Premedication Orders: Solu-Medrol 100mg IV, Tylenol 1000mg PO, and Benadryl 50mg PO/IV	<input type="checkbox"/> _____
<input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Plaque Psoriasis <b>ICD-10:</b> _____	<input type="checkbox"/> <b>Infliximab or infliximab biosimilar</b> as required by patient's insurance <input type="checkbox"/> Do not substitute. Infuse the following infliximab product: _____ For Paragon use only. Brand: _____ Dose: _____ mg/kg Frequency: <input type="checkbox"/> Every _____ weeks <b>OR</b> <input type="checkbox"/> 0, 2, 6 then every 8 weeks <b>Simponi Aria</b> Initial Dose: <input type="checkbox"/> 2mg/kg IV at weeks 0, 4 and then every 8 weeks Maintenance Dose: <input type="checkbox"/> 2mg/kg IV every 8 weeks <b>Stelara</b> <input type="checkbox"/> 45mg SQ initially and 4 weeks later followed by 45mg every 12 weeks ( $\leq 100$ kg) <input type="checkbox"/> 90mg SQ initially and 4 weeks later followed by 90mg every 12 weeks ( $>100$ kg) Maintenance Dose: <input type="checkbox"/> 45mg SQ every 12 weeks <b>OR</b> <input type="checkbox"/> 90mg SQ every 12 weeks <b>Ilumya</b> Initial Dose: <input type="checkbox"/> 100mg SQ at weeks 0, 4 and every 12 weeks thereafter Maintenance Dose: <input type="checkbox"/> 100mg SQ every 12 weeks <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 <input type="checkbox"/> 400mg SQ at weeks 0, 2, and 4 followed by <input type="checkbox"/> 200mg <input type="checkbox"/> 400mg every 2 weeks	<input type="checkbox"/> x1 year <input type="checkbox"/> _____
<input type="checkbox"/> Generalized Pustular Psoriasis <b>ICD-10:</b> _____	<input type="checkbox"/> <b>Spevigo</b> 900mg IV x 1 <input type="checkbox"/> Repeat Spevigo 900mg IV in 1 week if symptoms persist	

**Premedication orders:** Tylenol  1000mg  500mg PO, please choose one antihistamine:

 Diphenhydramine 25mg PO  Loratadine 10mg PO  Cetirizine 10mg PO  Quzyttir 10mg IVP

**Additional premedications:**  Solu-Medrol \_\_\_\_\_ mg IVP  Solu-Cortef \_\_\_\_\_ mg IVP  Other \_\_\_\_\_

**Lab orders:** \_\_\_\_\_ **Frequency:**  Every infusion  Other: \_\_\_\_\_

 Yearly TB QFT  Baseline HepBcAB total Required labs to be drawn by:  Paragon  Referring provider

**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): \_\_\_\_\_

**PREFERRED LOCATION**

City: \_\_\_\_\_ State: \_\_\_\_\_

View our locations here:



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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, Spevigo  
 **Positive**  **Negative**
- Hepatitis B screening (Hepatitis B surface antigen) -  Positive  Negative**  
*Required for: Cimzia, infliximab, rituximab, Simponi Aria*  
**Hepatitis B core antibody total (not IgM) -  Positive  Negative**  
*Required for: rituximab*
- Serum immunoglobulins - attach results** *Recommended for: rituximab*
- 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**