PARAGON HEALTHCARE

INTERNAL MEDICINE INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

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	
☐ Dehydration (ICD-10 _____) ☐ Gastroenteritis (ICD-10 _____) ☐ Other: _____ (ICD-10 _____)	☐ 1 Liter / ☐ 2 Liters D5 .45% NS IV x 1 ☐ 1 Liter / ☐ 2 Liters NS IV x 1 ☐ 1 Liter / ☐ 2 Liters LR IV x 1 ☐ May repeat dose x _____ days	
☐ Iron Deficiency Anemia (ICD-10 _____) ☐ Iron Deficiency Anemia with CKD not on dialysis (ICD-10 _____)	☐ **Venofer** 200mg IV - Administer 5 doses over a 14 day period ☐ **Venofer** 200mg IV weekly x 5 doses ☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt <50kg) ☐ **Injectafer** 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt ≥50kg) ☐ **Monoferric** 20mg/kg IV x 1 dose (wt <50kg) ☐ **Monoferric** 1000mg IV x 1 dose (wt ≥50kg)	
☐ Nausea/Vomiting (ICD-10 _____)	☐ **Zofran** 4mg IVP ☐ **Reglan** 10mg IV ☐ **Zofran** 8mg IVP	
☐ Pneumonia (ICD-10 _____)	☐ **Zithromax** 500mg IV daily x 3 days ☐ **Ivanz** 1mg IV daily x 7 days	
☐ Chronic Sinusitis (ICD-10 _____)	☐ **Rocephin** 2gms IV daily x 14 days	
☐ Chronic Bronchitis (ICD-10 _____)	☐ **Zithromax** 500mg IV daily x 3 days ☐ **Solu-Medrol** 125mg IVP x 1 day, then 62.5 mg IVP x 2 days	
☐ Pyelonephritis (ICD-10 _____) ☐ Complicated UTI (ICD-10 _____)	☐ **Rocephin** 2gms IV daily x 7 days ☐ **Ivanz** 1gm IV daily x 7 days	
☐ Cellulitis/MSSA (ICD-10 _____) ☐ Location: _____	☐ **Rocephin** 1gm IV daily x 7 days	
☐ MRSA (ICD-10 _____) ☐ Location: _____	☐ **Cubicin** 4mg/kg IV daily x _____ weeks ☐ **Cubicin** 4mg/kg IV daily x 7 days ☐ **Cubicin** _____	
☐ Multiple Sclerosis Exacerbation (ICD-10 _____)	☐ **Solu-Medrol** 1gm IV daily for ☐ 3 days ☐ 5 days	
☐ Migraines (ICD-10 _____)	☐ **Depacon** 500mg IV x 1 ☐ **DHE 45** 1mg IV (must premed for nausea) ☐ **Zofran** 4mg IVP, may repeat x 1 ☐ **Reglan** 10mg IV x 1	☐ **Magnesium Sulfate** 1 gram IV x 1 ☐ **Solu-Medrol** 125mg IVP x 1 ☐ **Toradol** 30mg IVP x 1 ☐ Repeat regimen x _____ days
☐ Other: _____ (ICD-10 _____)	☐ Other: _____	

Lab orders: _____ **Lab Frequency:** _____

Required labs to be drawn by ☐ Paragon Healthcare ☐ 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:*

PARAGON HEALTHCARE

COMPREHENSIVE SUPPORT FOR INFUSION THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

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 (H&P) to support primary diagnosis
  - ☐ For iron orders - Has the patient tried and failed or have a contraindication to oral iron? ☐ Yes ☐ No
- ☐ Labs
  - ☐ CPK (Cubicin order) - **(attach)** **can draw with first infusion if unavailable*
  - ☐ CBC, iron, Ferritin, Transferrin, TIBC (iron orders) - **(attach)**
  - ☐ LFTs (Depacon order) - **(attach)** **can draw with first infusion if unavailable*
- ☐ Culture results attached (if applicable)
- ☐ PICC/Central line placement confirmation (if applicable)
- ☐ Other medical necessity: _____

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