

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: _____

Primary ICD-10: _____

-
- Iron Deficiency Anemia
-
-
- Iron Deficiency Unspecified
-
-
- Iron Deficiency Anemia secondary to Inadequate Dietary Iron Intake
-
-
- Other medical necessity: _____

Secondary ICD-10: _____

-
- Adverse effect of other drug (oral iron intolerance or not adequate)
-
-
- End-stage Renal Disease
-
-
- Intestinal Malabsorption
-
-
- Chronic Kidney Disease
-
-
- Other medical necessity: _____

VENOFER THERAPY ORDER
 Venofer 200mg IV - Administer 5 doses over a 14 day period

 Venofer 200mg IV weekly x 5 weeks

 Other: _____

INJECTAFER THERAPY ORDER
****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first****
 Patient weighing less than 50kg (110 lbs.)

 Dose: Injectafer 15mg/kg IV
 Frequency: Give 2 doses at least 7 days apart not to exceed 1500mg

 Patient weighing 50kg (110 lbs.) or greater

 Dose: Injectafer 750mg IV
 Frequency: Give 2 doses at least 7 days apart not to exceed 1500mg

MONOFERRIC THERAPY ORDER
****If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first****
 Patient weighing less than 50kg (110 lbs.)

Dose: Monoferric 20mg/kg IV x 1 dose

 Patient weighing 50kg (110 lbs.) or greater

Dose: Monoferric 1000mg IV x 1 dose

Other orders: _____

Lab orders: _____ **Frequency:** _____

 Required labs to be drawn by: Paragon Referring physician

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
 - >30kg (>66lbs): EpiPen® 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
 - 15-30kg (33-66lbs): EpiPen® 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x 1
- Solu-Medrol 125mg IV as needed (adult), refer to provider orders or policy for pediatric dosing
- NS 250-500 mL IV bolus as needed (adult), refer to provider orders or policy for pediatric bolus

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

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 (H&P) to support primary diagnosis
 - Does the patient have an intolerance, contraindication, or documented tried and failed use of oral iron? Yes No
 - Does the patient have an intolerance or documented tried and failed use of an IV iron product? Yes No If yes, which drug(s)? _____
- Labs showing iron deficiency anemia attached
- Other medical necessity: _____

REQUIRED PRE-SCREENING

- Labs indicating iron deficiency - please attach**

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