

**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
<input type="checkbox"/> Mild Hyperemesis (ICD-10: O21.0) <input type="checkbox"/> Hyperemesis w/metabolic disturbance (ICD-10: O21.1) <input type="checkbox"/> Other: _____ (ICD-10: _____)	<input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters D5 .45 NS IV x 1 day <input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters NS IV x 1 day <input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters Ringers Lactate IV x 1 day <input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters D5/Ringers Lactate x 1 day <input type="checkbox"/> <b>Zofran</b> 4mg IVP x 1 <input type="checkbox"/> <b>Zofran</b> 8mg IVP x 1 <input type="checkbox"/> May repeat regimen x _____ days
<input type="checkbox"/> Iron Deficiency Anemia <input type="checkbox"/> Other medical necessity: _____ (ICD-10: _____)	<b>**If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first**</b> <input type="checkbox"/> <b>Venofer</b> 200mg IV - Administer 5 doses over a 14 day period <input type="checkbox"/> <b>Venofer</b> 200mg IV weekly x 5 doses <input type="checkbox"/> <b>Injectafer</b> 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt <50kg) <input type="checkbox"/> <b>Injectafer</b> 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt ≥50kg) <input type="checkbox"/> <b>Monoferric</b> 20mg/kg IV x 1 dose (wt <50kg) <input type="checkbox"/> <b>Monoferric</b> 1000mg IV x 1 dose (wt ≥50kg)
<input type="checkbox"/> Pyelonephritis <input type="checkbox"/> Complicated UTI <input type="checkbox"/> Other: _____ (ICD-10: _____)	<input type="checkbox"/> Rocephin 1gm IV daily x 7 days <input type="checkbox"/> Rocephin 2gms IV daily x 7 days <input type="checkbox"/> Ivanz 1gm IV daily x 7 days <input type="checkbox"/> Other: _____
<input type="checkbox"/> Migraines <input type="checkbox"/> Other: _____ (ICD-10: _____)	<input type="checkbox"/> Zofran 4mg IVP x 1 <input type="checkbox"/> Zofran 8mg IVP x 1 <input type="checkbox"/> Reglan 10mg IV x 1 <input type="checkbox"/> May repeat migraine regimen x _____ days <input type="checkbox"/> Mag sulfate 1 gram IV x 1 <input type="checkbox"/> Depacon 500mg IV x 1 <input type="checkbox"/> DHE 45 1mg IV x 1 <span style="float: right;">} Non-OB patients</span>
<input type="checkbox"/> Other: _____ (ICD-10: _____)	<input type="checkbox"/> 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:





## COMPREHENSIVE SUPPORT FOR OB/GYN 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
- Labs attached
  - CBC, Iron, Ferritin, Transferrin, TIBC (for iron orders) - **attach results**
  - Baseline LFTs (for Depacon orders) - **attach results** \*can draw with 1st infusion if not available
- 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**

PARAGONHEALTHCARE.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.