PARAGON HEALTHCARE

INFLIXIMAB 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:** ______________

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back)

MEDICAL INFORMATION

Patient Weight: ________ lbs. Allergies: ______________________________

Diagnosis: ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis

ICD-10: ______________ ☐ Psoriasis ☐ Other: __________________

THERAPY ORDER

Infliximab: *(choose one)*

- ☐ Infuse infliximab **OR** infliximab biosimilar as required by patient's insurance
  **Preferred product to be determine after benefits investigation (noted below)
- ☐ Do not substitute. Infuse the following infliximab product: __________________

Dose: ____________ mg/kg

Frequency: ☐ 0, 2, 6 weeks, then every 8 weeks (initial start) x1 year

☐ Every ____________ weeks (maintenance dose) x1 year

☐ Other ____________________________________

Premedication orders: Tylenol ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO

Additional premedications: ☐ Solu-Medrol __________ mg IVP ☐ Solu-Cortef __________ mg IVP
☐ Other ________________________________

Lab orders: ________________________ **Frequency:** ☐ Every infusion ☐ Other: ____________
☐ Yearly TB testing QFT (optional)

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 x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- NS 0.9% 500mL IV bolus as needed (adult)
- Refer to physician order or institutional protocol for pediatric dosing

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

*FOR PARAGON USE ONLY

Drug/Brand Selection: ______________________

PROVIDER INFORMATION Orders are good for one year from the signature date

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

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.

© 2022 Paragon Healthcare, Inc.

PARAGON HEALTHCARE

COMPREHENSIVE SUPPORT FOR INFLIXIMAB THERAPIES

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 to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)? ☐ Yes ☐ No
    If yes, which drug(s)? ______________________________
  - ☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara, Cimzia)? ☐ Yes ☐ No
    If yes, which drug(s)? ______________________________
  - ☐ If psoriasis diagnosis, percent of body surface (BSA) involved: __________ %
- ☐ 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 infliximab.
- ☐ Other medical necessity: ______________________________

REQUIRED PRE-SCREENING

- ☐ **TB screening test completed within 12 months - attach results**
  ☐ **Positive** ☐ **Negative**

- ☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - attach results**
  ☐ **Positive** ☐ **Negative**

*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

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.

© 2022 Paragon Healthcare, Inc.