

**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**

ICD-10 Code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

 Patient Weight: \_\_\_\_\_ lbs. (required) Height: \_\_\_\_\_ Diabetic  Yes  No

Allergies: \_\_\_\_\_

 First Dose:  Yes  No Date of Last Infusion: \_\_\_\_\_ Brand previously used: \_\_\_\_\_

**THERAPY ORDER**
**Ig Orders:**  IV \_\_\_\_\_ **gm/kg** divided over \_\_\_\_\_ day(s)  
 Sub Q \_\_\_\_\_ **mg/kg** divided over \_\_\_\_\_ day(s)  
 \_\_\_\_\_ **grams** divided over \_\_\_\_\_ day(s)

**Frequency:**  Repeat dose every \_\_\_\_\_ weeks for 1 year  
 Repeat dose every \_\_\_\_\_ weeks for \_\_\_\_\_ weeks total

- **Pharmacist to identify clinically appropriate Ig brand and infusion rates. May substitute based on product availability.**  
 Do not substitute. Administer brand: \_\_\_\_\_
- Infuse entire contents of Ig infusion bag/vial(s) per current dose.
- If needed, round dose to nearest whole 5 gm vial for IV doses and nearest single-use vial size for subQ doses.

**Pre-Medication Orders:** *to be administered 15-30 minutes before infusion*

- |  |   |
|--|---|
| <input type="checkbox"/> Acetaminophen 500mg PO  | <input type="checkbox"/> Normal Saline 500mL IV   |
| <input type="checkbox"/> Cetirizine 10mg PO      | <input type="checkbox"/> Solu-Medrol _____ mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Quzyttir 10mg IVP        |
| <input type="checkbox"/> Loratadine 10mg PO      | <input type="checkbox"/> Other: _____             |

**Lab Orders:** \_\_\_\_\_ **Lab frequency:**  Each infusion  Other: \_\_\_\_\_

 Required labs to be drawn by  Paragon Healthcare  Referring Provider

**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
- Diphenhydramine - Administer 25-50mg orally OR IV (adult), refer to provider orders or policy for pediatric dose
- NS 500 mL IV bolus as needed for IVIg therapy (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

**\*FOR PARAGON USE ONLY**

Drug/Brand Selection: \_\_\_\_\_ Date: \_\_\_\_\_

NP/Pharmacist Name: \_\_\_\_\_ NP/Pharmacist Signature: \_\_\_\_\_

**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

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.

**REQUIRED DOCUMENTATION FOR INSURANCE APPROVAL**  
GENERAL REQUIREMENTS

- Patient demographics
- Insurance information
- All applicable diagnoses
- History and physical
- Recent progress notes within 12 months
- Patient's height and weight
- Drug allergies
- Physician Orders
- Plus one of the following

**COMMON VARIABLE IMMUNODEFICIENCY (CVID) /  
HYPOGAMMAGLOBULINEMIA / PARKINSON'S DISEASE (PD)**

- Lab last showing Ig levels and subclasses Ig levels.
- Documentation of recurrent infections
- History of antibiotic usage - showing failure to respond to antibiotics
- Documented inadequate response to pneumococcal vaccine or tetanus/diphtheria

**CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) /  
GUILLAIN-BARRÉ SYNDROME (GBS)**

- Labs
- Nerve conduction study, electromyography (EMG)
- Nerve and/or muscle biopsy (if available)
- Nerve conduction velocity (NCV) test results
- Tried and failed treatments
- Spinal tap (if available)

**MYASTHENIA GRAVIS**

- Exacerbation
- Any history of crisis
- Thymectomy
- Any symptoms that affect respiration, speech or motor function
- Tried and failed treatments