PARAGON HEALTHCARE

IRON 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: ______________________

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 as least 7 days apart not to exceed 1500mg

☐ **Patient weighing 50kg (110 lbs.) or greater**
Dose: Injectafer 750mg IV
Frequency: Give 2 doses as 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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PARAGON HEALTHCARE

COMPREHENSIVE SUPPORT FOR IRON 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
  - ☐ 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

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