

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: _____

Lab orders: _____ **Frequency:** Each infusion Other: _____

 Required labs to be drawn by: Paragon Referring provider

THERAPY ORDER

Diagnosis	Infusion Orders
<input type="checkbox"/> Pompe Disease ICD-10: _____	<input type="checkbox"/> Lumizyme 20mg/kg IV every 2 weeks x1 year <input type="checkbox"/> Nexviazyme 20mg/kg IV every 2 weeks x1 year
<input type="checkbox"/> Acute Migraines ICD-10: _____	Premedication: <input type="checkbox"/> Zofran 4mg IVP <input type="checkbox"/> Zofran 8mg IVP <input type="checkbox"/> Pepcid IV 20mg IVP <input type="checkbox"/> Toradol 30mg IVP <input type="checkbox"/> Solu-Medrol 125mg IVP <input type="checkbox"/> Reglan 10mg IV/100mL NS over 20 minutes <input type="checkbox"/> Benadryl 25mg IV Protocol: <input type="checkbox"/> Depacon <input type="checkbox"/> 500mg <input type="checkbox"/> 750mg IV in 250mL NS <input type="checkbox"/> Magnesium Sulfate 1gm IV in 250mL <input type="checkbox"/> DHE 45 <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg IV in 100mL NS (<i>must premed for nausea</i>) Standing PRN Order: <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months Repeat regimen daily for _____ days/wk
<input type="checkbox"/> Migraines ICD-10: _____	Vyepiti: <input type="checkbox"/> 100mg IV every 3 months x1 year OR <input type="checkbox"/> 300mg IV every 3 months x1 year
<input type="checkbox"/> MS <input type="checkbox"/> Other: _____ ICD-10: _____	<input type="checkbox"/> Solu-Medrol 1gm IV daily x _____ days OR <input type="checkbox"/> Solu-Cortef 1gm IV daily x _____ days
<input type="checkbox"/> Diagnosis: _____ ICD-10: _____	Soliris: <input type="checkbox"/> 900mg IV weekly for the first 4 weeks, followed by 1200mg for the fifth dose 1 week later, then 1200mg every 2 weeks thereafter x1 year (initial start with maintenance) <input type="checkbox"/> 1200mg IV every 2 weeks x1 year (maintenance dosing)
<input type="checkbox"/> Multiple Sclerosis ICD-10: _____	<input type="checkbox"/> Tysabri 300mg IV every 4 weeks (after registering patient with TOUCH) <input type="checkbox"/> Ocrevus <input type="checkbox"/> 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months x1 year <input type="checkbox"/> 600mg IV every 6 months x1 year Premedication Protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO to be given 30 minutes before infusion
<input type="checkbox"/> Diagnosis: _____ ICD-10: _____	IVIg Orders: _____ mg/kg OR _____ gm/kg IV divided over _____ day(s) Frequency: Every _____ weeks x1 year OR _____ one time dose only Preferred brand: _____ (Paragon to choose if not indicated)
<input type="checkbox"/> Diagnosis: Myasthenia Gravis ICD-10: _____	Ultomiris: Loading dose: <input type="checkbox"/> 2,400mg (40-59kg) <input type="checkbox"/> 2,700mg (60-99kg) <input type="checkbox"/> 3,000mg (100kg+) IV followed 2 weeks later by Maintenance dose of: <input type="checkbox"/> 3,000mg (40-59kg) <input type="checkbox"/> 3,300mg (60-99kg) <input type="checkbox"/> 3,600mg (100kg+) IV every 8 weeks x1 year Vyvgart: <input type="checkbox"/> 10mg/kg IV once weekly for 4 weeks (<120kg) <input type="checkbox"/> 1200mg IV over 1 hour once weekly for 4 weeks (≥120kg)
<input type="checkbox"/> hATTR amyloidosis ICD-10: _____	<input type="checkbox"/> Amyvuttra 25mg SubQ every 3 months x1 year
Pre-medication Orders	<input type="checkbox"/> Tylenol 1000mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Benadryl 25mg PO <input type="checkbox"/> Benadryl 25mg IV <input type="checkbox"/> Loratadine 10mg PO <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Other: _____

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
 - Has the patient tried and failed previous drug therapy?
If yes, which drug(s)? _____
- Labs attached
 - JCV antibody (Tysabri orders)
 - AChR antibody (Vyvgart & Ultomiris)
 - Hepatitis B antigen and Hepatitis B core total (Ocrevus orders)
 - Other supporting labs based on diagnosis/order
- Diagnostic testing
 - MRI documentation (Tysabri and Ocrevus)
 - Other diagnostic testing to support diagnosis/order
- Vaccine record
 - Meningococcal vaccinations - both Men B and Men ACWY (Soliris & Ultomiris orders)
- 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