



HOME PARENTERAL NUTRITION (TPN) ORDER FORM

P: 866.972.5888 | F: 866.491.5888

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 866.491.5888

Name: _____	<input type="checkbox"/> Demos attached	Line Access
DOB: _____		<input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> Other
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Lumens: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Weight: _____ <input type="checkbox"/> lbs <input type="checkbox"/> kg	Height: _____	<input type="checkbox"/> Central Line needed

ORDER INFORMATION

Diagnosis/Indication for TPN therapy: _____ Date: _____

Rx Order: Paragon Healthcare to provide Home Parenteral Nutrition (PN)/TPN Therapy

TPN MANAGEMENT - FOR CUSTOM CONSULT, CHECK THE BOX

Check Please

The Paragon Nutrition Support Team (NST) will provide evidence-based, customized home PN management to optimize patient outcomes. Checking the box authorizes Paragon’s NST to assess and write orders for the initial TPN formula and to make ongoing changes to the TPN prescription including adjustments to electrolytes and macronutrients, volume and daily infusion duration, lab order management, and home health coordination with subsequent notification to the treating provider.

Treating provider managed TPN - Paragon will not provide recommendations for changes. Please include your custom order form.

REQUIRED INFORMATION

Length of Need Statement (LON)

- MUST be included in a progress note and signed by the prescriber
- Example of LON: “Due to patient’s [condition], TPN is needed for [insert amount of time here].”
- Medicare requires patient to have a permanent impairment considered long and indefinite in duration
- Note: Medicare does recognize time frames such as “lifetime” as appropriate

Must also include enteral contraindication

- What prevents patient from having a feeding tube?

Fax order form along with face sheet to: (866) 491-5888

Main Pharmacy Number: (866) 972-5888

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:



PARAGONHEALTHCARE.COM

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