

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL INFORMATION**

ICD-10 code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

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

Weight: \_\_\_\_\_ kg Height: \_\_\_\_\_ inches

 BSA: \_\_\_\_\_ m<sup>2</sup>  
*(if applicable)*

- 
- Call for weight change greater than 10% from baseline
- 
- 
- No dose modifications required for any weight change

**LAB ORDERS OR OTHER TESTS RELATED TO TREATMENT**

- 
- CBC w/plts, diff
- 
- TSH
- 
- LVEF done: \_\_\_\_\_/Ejection fraction: \_\_\_\_\_%
- 
- 
- CMP
- 
- Creatinine
- 
- Urine pregnancy test
- 
- 
- LFTs
- 
- Renal Function
- 
- Other: \_\_\_\_\_

 Lab frequency:  Prior to each cycle    Other: \_\_\_\_\_      Labs to be drawn by:  Infusion Center    Referring Provider

**HOLD PARAMETERS - PLEASE INDICATE**

- 
- No hold parameters for ANC/Platelets
- 
- No hold parameters
- 
- 
- Hold and call for LFTs 3x ULN and/or Bili 1.5x ULN
- 
- Hold and call for creatinine 1.5x ULN
- 
- 
- Hold and call for ANC: \_\_\_\_\_/Platelets: \_\_\_\_\_
- 
- 
- Other hold parameters: \_\_\_\_\_

**PRE-MED AND ANTIEMETIC ORDERS**

- 
- Zofran \_\_\_\_\_ mg IV
- 
- Decadron \_\_\_\_\_ mg IV
- 
- Benadryl \_\_\_\_\_ mg IV
- 
- Pepcid \_\_\_\_\_ mg IV
- 
- 
- Reglan \_\_\_\_\_ mg IV
- 
- Solu-Medrol \_\_\_\_\_ mg IV
- 
- Benadryl \_\_\_\_\_ mg PO
- 
- Tylenol \_\_\_\_\_ mg PO
- 
- 
- Granisetron \_\_\_\_\_ mg IV
- 
- Hydration/other: \_\_\_\_\_      Frequency:
- 
- PRN
- 
- Standing order
- 
- \_\_\_\_\_

**TREATMENT ORDER**
**\*\* All available drugs listed on Page 2\*\***

Date/Day	Drug	Dosing (i.e., mg/kg)	Calculated Dose	Route	Frequency	Special Instructions <small>*Volume, diluent, &amp; rate set by Paragon unless otherwise noted here</small>

Date of last infusion: \_\_\_\_\_ Cycle number: \_\_\_\_\_

Subsequent treatments may be given +/- \_\_\_\_\_ days

This order is good for \_\_\_\_\_ cycles from the date ordered. Next appointment with Oncologist: \_\_\_\_\_

Call referring provider for: \_\_\_\_\_

Oral treatment patient is on: \_\_\_\_\_

Other orders/information: \_\_\_\_\_

**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: \_\_\_\_\_

**PREFERRED LOCATION**

City: \_\_\_\_\_ State: \_\_\_\_\_

View our locations here:



**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL**

- Patient demographics including insurance information (copies of insurance cards preferred)
- Treatment orders - include drugs, dose, frequency, administration, and cycle definition
- Pre-medication orders (including glucocorticoids) - *if applicable*
- Supportive therapy orders (including anti-emetics, CSFs, hydration, antibiotics) - *if applicable*
- Note: oral prescriptions need to be filled at local pharmacy prior to infusion
- Monitoring and hold parameters
- Dose adjustment protocol, where applicable (i.e., weight changes, lab parameters)
- Standing orders (infusion reactions, management of CVC occlusion, etc.)
- Lab orders - if labs need to be drawn by Paragon
- Clinical chart notes within the last 12 months
- Recent lab results & diagnostic results
- Medication list, if available
- Date of last cycle or infusion dose
- Next follow-up visit with Oncologist

**Oncology Therapies Available:**

ado-trastuzumab*	fam-trastuzumab*	pemetrexed*
amivantamab	fulvestrant*	pertuzumab*
bevacizumab & biosimilars	ipilimumab	pertuzumab/trastuzumab/hyaluronidase*
bortezomib*	lantreotide	rituximab & biosimilars
brentuximab vedotin*	leuprolide acetate	sirolimus*
daratumumab & hyaluronidase	loncastuximab*	tisotumab vedotin*
denosumab	octreotide	trastuzumab & biosimilars
dostarumab	pegfilgrastim	triptorelin pamoate*
durvalumab	pembrolizumab	

\*only available at certain locations

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) 475-5865 or call (855) 505-2348 for assistance  
 oncology@paragonhealthcare.com**

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.