PH: 833.862.4559
FAX: 855.862.4373

PARAGON HEALTHCARE
A Carelon Company

Hemophilia Order Form

PATIENT INFORMATION

☐ *demographics attached*

Patient Name: _____ DOB: _____ Sex: ☐M ☐F
Address: _____ Patient SSN: _____
City: _____ State: _____ Zip: _____ Phone: _____
Email: _____ Alt. Phone: _____
Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION: *PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK*

If patient is on Parent/Guardian's insurance, please complete below:
Parent/Guardian Name: _____ Relationship: _____
Parent/Guardian SSN: _____ DOB: _____ Phone: _____

HOME HEALTH INFORMATION

Current Home Health: _____ Phone: _____
☐ *Please check this box if patient does not currently have Home Health*

MEDICAL INFORMATION

Height: _____ Weight: _____ Allergies: _____
Primary Diagnosis: _____ Diagnosis Code: _____
Secondary Diagnosis: _____ Diagnosis Code: _____
Bleeding Disorder Type: ☐Hemo A ☐Hemo B ☐VWD ☐FX ☐Other: _____ Inhibitors: ☐Yes ☐No
Severity: ☐Mild ☐Moderate ☐Severe ☐Type VWD: _____
Is patient followed at a Hemophilia Treatment Center? ☐ Yes ☐ No
If Yes, where? _____
Access: ☐ Peripheral IV ☐ Port ☐ Central Line ☐ PICC Line ☐ SubQ
Misc. Medical Supplies: ☐ Ambulatory IV Infusion Pump ☐ Infusion Pump Pole ☐ Subcutaneous Infusion Pump
☐ Other: _____

PRESCRIPTION INFORMATION

DRUG

☐ Advate®
☐ Adynovate®
☐ Alhemo®
☐ Aprolix®
☐ Altuviiio®
☐ Coagadex®
☐ Eloctate®
☐ Esperoct®
☐ Feiba®
☐ Hemlibra®
☐ Humate-P®
☐ Hympavzi®
☐ Idelvion®
☐ IXINTIY®
☐ Jivi®
☐ Koate® DVI
☐ Kovaltry®
☐ Novoeight®
☐ NovoSeven®
☐ Nuwiq®
☐ Rixubis®
☐ Von Vendi®
☐ Wilate®
☐ Xyntha®

☐ Other _____

DRUG STRENGTH

Drug Strength (in Units +/- 10%): _____

DIRECTIONS

QUANTITY: _____ **REFILLS** _____

☐ Product Selection Permitted ☐ Dispense as Written

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____
Physician Name: _____ Tax ID: _____
NPI: _____ DEA: _____ License: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____ Contact Person: _____