PARAGON HEALTHCARE

INFLIXIMAB 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:** _____

INSURANCE INFORMATION:

Please attach a copy of insurance cards (front and back)

MEDICAL INFORMATION

Patient Weight: _____ lbs. Allergies: _____

Diagnosis: ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis

ICD-10: _____ ☐ Psoriasis ☐ Other: _____

THERAPY ORDER

Infliximab: *(choose one)*

☐ Infuse infliximab **OR** infliximab biosimilar as required by patient's insurance

**Preferred product to be determine after benefits investigation (noted below)

☐ Do not substitute. Infuse the following infliximab product: _____

Dose: _____ mg/kg

Frequency: ☐ 0, 2, 6 weeks, then every 8 weeks (initial start) x1 year

☐ Every _____ weeks (maintenance dose) x1 year

☐ Other _____

Premedication orders: Tylenol ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Cetirizine 10mg IVP

Additional premedications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP
☐ Other _____

Lab orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

☐ Yearly TB testing QFT ☐ Baseline HepBcAB total Required labs to be drawn by: ☐ Paragon ☐ Referring MD

Home IV Biologic Ana-kit Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- NS 0.9% 1000mL IV bolus per protocol PRN (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

*FOR PARAGON USE ONLY

Drug/Brand Selection: _____

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:*

PARAGON HEALTHCARE

COMPREHENSIVE SUPPORT FOR INFLIXIMAB THERAPIES

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 to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)? ☐ Yes ☐ No
  If yes, which drug(s)? _____
- ☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara, Cimzia)? ☐ Yes ☐ No
  If yes, which drug(s)? _____
- ☐ If psoriasis diagnosis, percent of body surface (BSA) involved: _____ %

☐ Include labs and/or test results to support diagnosis

☐ *If applicable* - Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting infliximab.

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ **TB screening test completed within 12 months - attach results**
☐ **Positive** ☐ **Negative**

☐ **Hepatitis B screening test completed (Hepatitis B antigen) - attach results**
☐ **Positive** ☐ **Negative**

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

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