



**PHYSICIAN  
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**

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

Patient Weight: \_\_\_\_\_ lbs. (required) Allergies: \_\_\_\_\_

**PHYSICIAN ORDER**

**Lab Orders:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**Other Orders:** \_\_\_\_\_

**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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## COMPREHENSIVE SUPPORT FOR INFUSION THERAPY

### 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 (H&P) to support primary diagnosis
- Labs attached (if applicable)
- Diagnostics attached (if applicable)
- Medical necessity (if applicable): \_\_\_\_\_

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**

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