PARAGON HEALTHCARE

A Carelon Company

IMMUNOGLOBULIN (IG) IV AND SUBQ ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:	ZIP:	
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

☐ **IV** ☐ **SubQ** **Pharmacist to identify clinically appropriate brand/infusion rates. May substitute based on product availability.**

Loading Dose ***(as applicable)***	_____	☐ mg/kg ☐ gm/kg ☐ grams	x ___ day(s) **OR** divided over ___ day(s)	☐ One time dose ☐ Other: _____ ** Give maintenance dose ___ weeks after loading dose**
Maintenance Dose	_____	☐ mg/kg ☐ gm/kg ☐ grams	x ___ day(s) **OR** divided over ___ day(s)	☐ Q _____ weeks x1 year ☐ Other: _____

☐ Do not substitute. Administer brand: _____

- Infuse entire contents of Ig infusion bag/vial(s) per current dose.
- If needed, round dose to nearest whole 5 gm vial for IV doses and nearest single-use vial size for subQ doses.

Pre-Medication Orders: *to be administered 15-30 minutes before infusion*

☐ Acetaminophen 500mg PO	☐ Normal Saline 500mL IV	☐ Cetirizine 10mg PO
☐ Solu-Medrol _____ mg IVP	☐ Diphenhydramine 25mg PO	☐ Cetirizine 10mg IVP
☐ Loratadine 10mg PO	☐ Diphenhydramine 25mg IV	☐ Other: _____

Lab Orders: _____ **Lab frequency:** ☐ Each infusion ☐ Other: _____

Required labs to be drawn by ☐ Paragon Healthcare ☐ Referring Provider

Home IV Biologic Ana-kit Orders (adult):
- Epinephrine: >30kg (>66lbs): EpiPen 0.3mg IM; 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)

Home biologic injection Ana-kit (adult):
- Dispense per protocol EpiPen 0.3mg IM (2-pack)

Refer to physician order or institutional protocol for pediatric dosing Ana-kit
Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN
Supply IV Infusion Pump (E0781) and/or SubQ Infusion Pump (E0779) as needed

*FOR PARAGON USE ONLY

Drug/Brand Selection: _____ Date: _____

NP/Pharmacist Name: NP/Pharmacist Signature

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

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.

Prescriber Signature: X	**Date:**

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COMPREHENSIVE SUPPORT FOR IMMUNOGLOBULIN THERAPY

PATIENT INFORMATION

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 current medication list
☐ Supporting clinical notes (H&P) to support primary diagnosis - Including tried/failed medications

☐ Plus one of the following:

COMMON VARIABLE IMMUNODEFICIENCY (CVID) /HYPOGAMMAGLOBULINEMIA / PARKINSON'S DISEASE (PD)

- ☐ Lab last showing Ig levels and subclasses Ig levels.
- ☐ Documentation of recurrent infections
- ☐ History of antibiotic usage - showing failure to respond to antibiotics
- ☐ Documented inadequate response to pneumococcal vaccine or tetanus/diphtheria

CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP) /GUILLAIN-BARRÉ SYNDROME (GBS)

- ☐ Labs
- ☐ Nerve conduction study, electromyography (EMG)
- ☐ Nerve and/or muscle biopsy (if available)
- ☐ Nerve conduction velocity (NCV) test results
- ☐ Tried and failed treatments
- ☐ Spinal tap (if available)

MYASTHENIA GRAVIS

- ☐ Exacerbation
- ☐ Any history of crisis
- ☐ Thymectomy
- ☐ Any symptoms that affect respiration, speech or motor function
- ☐ Tried and failed treatments