PARAGON HEALTHCARE
A Carelon Company

GASTROENTEROLOGY ORDER SET

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:**

MEDICAL INFORMATION

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Diagnosis	Medication Orders	Refills
☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other: _____ **ICD-10 Code:** _____	☐ **Cimzia** 400mg subQ at weeks 0, 2, 4 and then every 4 weeks ☐ **Cimzia** _____ mg subQ every _____ weeks ☐ **Infliximab or infliximab biosimilar** as required by patient's insurance ☐ Do not substitute**.** Infuse the following infliximab product: _____ *For Paragon use only*. Brand: _____ Dose: _____ mg/kg Frequency: ☐ Every ____ weeks OR ☐ 0, 2, 6 then every 8 weeks ☐ **Skyrizi** initial infusion: ☐ 600mg or ☐ 1200mg IV at week 0, 4, and 8 weeks ☐ **Skyrizi** maintenance*: ☐ 180mg or ☐ 360mg subQ at week 12, and every 8 weeks thereafter ☐ **Stelara** initial infusion: ☐ 260mg ☐ 390mg ☐ 520mg IV x 1 dose ☐ **Stelara** maintenance*: ☐ 90mg SQ 8 weeks after initial infusion and then every 8 weeks thereafter ☐ **Entyvio** 300mg IV at 0, 2, 6 weeks and then Q8 weeks ☐ **Entyvio** 300mg IV every 8 weeks ☐ **Entyvio** 300mg IV at 0 and 2 weeks (IV to subQ dosing) ☐ **Omvoh** (initial infusion): ☐ 300mg or ☐ 900mg IV at 0, 4, and 8 weeks ☐ **Omvoh** (maintenance)*: ☐ 200mg or ☐ 300mg subQ at week 12, then every 4 weeks ☐ **Tremfya** (initial infusion): 200mg IV at 0, 4, and 8 weeks ☐ **Tremfya** (maintenance)*: ☐ 100mg subQ at week 16, then every 8 weeks thereafter OR ☐ 200mg subQ at week 12, then every 4 weeks thereafter *SubQ maintenance doses are filled by Paragon Specialty Pharmacy as applicable	☐ _____ ☐ x1 year

ICD-10 Code: _____
☐ Iron Deficiency Anemia
☐ Iron Deficiency Anemia w/CKD
☐ Other: _____
** If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first or have a letter of medical necessity**

☐ Venofer 200mg IV - Administer 5 doses over a 14 day period
☐ Venofer 200mg IV weekly x 5 weeks
☐ Injectafer 15mg/kg IV (<50kg) - Give 2 doses at least 7 days apart
☐ Injectafer 750mg IV (≥50kg) - Give 2 doses at least 7 days apart
☐ Monoferric 1000mg IV x1 dose (≥50kg)
☐ Monoferric 20mg/kg IV x1 dose (<50kg)

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 QFT ☐ Baseline HepBcAB total Required labs to be drawn by: ☐ Paragon Healthcare ☐ Referring Provider
Home biologic IV Ana-kit (adult): Dispense EpiPen 0.3mg IM (2-pack) or compounded syringe, diphenhydramine 50mg IV and PO, NS 1000mL
Home biologic injection Ana-kit (adult): EpiPen 0.3mg IM (2-pack)

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:*

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.

PARAGON HEALTHCARE

A Carelon Company

COMPREHENSIVE SUPPORT FOR GASTROENTEROLOGY 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 to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., 6MP, azathioprine)? ☐ Yes ☐ No
    If yes, which drug(s)? _____
  - ☐ For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Humira, Stelara, Cimzia)? ☐ Yes ☐ No
    If yes, which drug(s)? _____
- ☐ Include labs and/or test results to support diagnosis
- ☐ *If applicable* - Last known biological therapy: _____ and last date received: _____. If patient is switching biologic therapies, please perform a wash-out period of _____ weeks prior to starting ordered biologic therapy.
- ☐ Other medical necessity: _____

REQUIRED PRE-SCREENING (BASED ON DRUG THERAPY)

- ☐ **TB screening test completed within 12 months - attach results**
  Required for: Cimzia, Infliximab, Stelara, Entyvio, Skyrizi, Omvoh, Tremfya
  ☐ **Positive** ☐ **Negative**
- ☐ **Hepatitis B screening test completed (Hepatitis B surface antigen) - attach results**
  Required for: Cimzia, Infliximab
  ☐ **Positive** ☐ **Negative**
- ☐ **Liver function tests & bilirubin** Required for: Skyrizi, Omvoh
- ☐ **Labs indicating iron deficiency** Required for: Venofer, Injectafer, Monoferric

*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

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.