

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

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Allergies:				
Diagnosis Code ICD-10: (required)			Diagnosis Description:	
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> 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)

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

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)

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.	<input type="checkbox"/> 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:
--------------------------------	--------------

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & 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
 - Rheum - 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)? _____
 - Rheum - Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Simponi, Xeljanz, infliximab)? Yes No
If yes, which drug(s)? _____
 - CRS dx - Has the patient received treatment with a chimeric antigen receptor T cell therapy (i.e., Kymriah, Yescarta) or Blincyto? Yes No If yes, which drug(s)? _____
- Include labs and/or test results to support diagnosis
 - Rheumatoid Factor or anti-CCP (attach results)
 - Temporal artery biopsy or cross-sectional imaging or acute-phase reactant elevation (GCA dx)
- 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 Actemra.
- Other medical necessity: _____

REQUIRED PRE-SCREENING (BASED ON DRUG THERAPY)

- TB screening test (completed within 12 months if a new start) - attach results**
 - Positive Negative
- Hepatitis B screening test completed (Hepatitis B surface antigen) - attach results**
 - Positive Negative
- CBC w/diff, LFTs, Lipid Panel - attach results**

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