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

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)

Drug	Dosing	Refills
Cimzia (certolizumab pegol)	☐ 400mg subQ at weeks 0, 2, 4 and then every 4 weeks ☐ _____ mg subQ every _____ weeks	☐ x1 year ☐ _____
Entyvio (vedolizumab)	☐ 300mg IV at 0, 2, 6 weeks and then Q8 weeks ☐ 300mg IV every 8 weeks ☐ 300mg IV at 0 and 2 weeks (IV to subQ dosing)	☐ x1 year ☐ _____
Skyrizi (risankizumab)	Initial infusion: ☐ 600mg or ☐ 1200mg IV at week 0, 4, and 8 weeks Maintenance*: ☐ 180mg or ☐ 360mg subQ at week 12, and every 8 weeks thereafter	☐ x1 year ☐ _____
☐ **Ustekinumab or ustekinumab biosimilar** (as required by patient's insurance) ☐ Do not substitute. Infuse the following ustekinumab product: _____	Initial infusion: ☐ 260mg ☐ 390mg ☐ 520mg IV x 1 dose Maintenance*: ☐ 90mg SQ 8 weeks after initial infusion and then every 8 weeks thereafter *For Paragon use only*. Brand: _____	☐ x1 year ☐ _____
Omvoh (mirikizumab)	Initial infusion: ☐ 300mg or ☐ 900mg IV at 0, 4, and 8 weeks Maintenance*: ☐ 200mg or ☐ 300mg subQ at week 12, then every 4 weeks	☐ x1 year ☐ _____
Tremfya (guselkumab)	Initial infusion: 200mg IV at 0, 4, and 8 weeks Maintenance*: ☐ 100mg subQ at week 16, then every 8 weeks thereafter OR ☐ 200mg subQ at week 12, then every 4 weeks thereafter	☐ x1 year ☐ _____
☐ **Infliximab or infliximab biosimilar** (as required by patient's insurance) ☐ Do not substitute. Infuse the following infliximab product: _____	Dose: _____ mg/kg IV Frequency: ☐ 0, 2, 6 then every 8 weeks ☐ Every ____ weeks *For Paragon use only*. Brand: _____	☐ x1 year ☐ _____

*SubQ maintenance doses are filled by Paragon Specialty Pharmacy as applicable

Premedication orders: Aceteminophen ☐ 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

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.

X: **Date:**

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COMPREHENSIVE SUPPORT FOR GASTROENTEROLOGY 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 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

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