PARAGON HEALTHCARE

A Carelon Company

DERMATOLOGY 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
☐ Dermatomyositis ☐ Polymyositis ☐ Pemphigoid/Pemphigus ☐ Other: _____ **ICD-10:** _____	**IVIg** Orders: _____ mg/kg **OR** _____ gm/kg IV x _____ day(s) **OR** divided over ____ day(s) **Frequency:** Every _____ weeks OR _____ Preferred brand: _____ (Paragon to choose if not indicated) Additional Ig orders: _____	☐ x1 year ☐ _____
☐ CIU **ICD-10:** _____	☐ **Xolair** ☐ 150mg SQ every 4 weeks ☐ 300mg SQ every 4 weeks Note: Patient must have an EpiPen in their possession on their appointment date	☐ x1 year ☐ _____
☐ Pemphigus Vulgaris **ICD-10:** _____	☐ **Rituximab or rituximab biosimilar** as required by patient's insurance ☐ Do not substitute**.** Infuse the following rituximab product: _____ *For Paragon use only*. Brand: _____ Initial Dose: ☐ 1000mg IV at day 0, 15 days Maintenance Dose: ☐ 500mg IV at month 12 and every 6 months thereafter Other dose: _____ Protocol Premedication Orders: Solu-Medrol 100mg IV, Tylenol 1000mg PO, and Benadryl 50mg PO/IV	☐ _____
☐ Psoriatic Arthritis ☐ Psoriasis ☐ Plaque Psoriasis **ICD-10:** _____	☐ **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 **Simponi Aria** Initial Dose: ☐ 2mg/kg IV at weeks 0, 4 and then every 8 weeks Maintenance Dose: ☐ 2mg/kg IV every 8 weeks **Stelara** ☐ 45mg SQ initially and 4 weeks later followed by 45mg every 12 weeks (≤ 100kg) ☐ 90mg SQ initially and 4 weeks later followed by 90mg every 12 weeks (>100kg) Maintenance Dose: ☐ 45mg SQ every 12 weeks OR ☐ 90mg SQ every 12 weeks **Ilumya** Initial Dose: ☐ 100mg SQ at weeks 0, 4 and every 12 weeks thereafter Maintenance Dose: ☐ 100mg SQ every 12 weeks **Cimzia** ☐ 200mg SQ every 2 weeks ☐ 400mg SQ every 4 weeks ☐ 400mg SQ every 2 weeks ☐ 400mg SQ at weeks 0, 2, and 4 followed by ☐ 200mg ☐ 400mg every 2 weeks	☐ x1 year ☐ _____
☐ Generalized Pustular Psoriasis **ICD-10:** _____	☐ **Spevigo** 900mg IV x 1 ☐ Repeat Spevigo 900mg IV in 1 week if symptoms persist	

Premedication orders: Tylenol ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Quzyttir 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 ☐ Referring provider

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 DERMATOLOGY 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., steroids)? ☐ 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., 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 to 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, Ilumya, Simponi Aria, Spevigo
☐ **Positive** ☐ **Negative**

☐ **Hepatitis B screening (Hepatitis B surface antigen) - ☐ Positive ☐ Negative**
Required for: Cimzia, infliximab, rituximab, Simponi Aria
Hepatitis B core antibody total (not IgM) - ☐ Positive ☐ Negative
Required for: rituximab

☐ **Serum immunoglobulins - attach results** *Recommended for: rituximab*

☐ **Baseline creatinine** Required for: IVIG

*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