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

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	Medication Orders	Refills
Cimzia (certolizumab pegol)	☐ 400mg SubQ at weeks 0, 2, and 4, followed by ☐ 200mg ☐ 400mg every 2 weeks ☐ 200mg SubQ every 2 weeks ☐ 400mg SubQ every 4 weeks ☐ 400mg SubQ every 2 weeks	☐ x1 year ☐ _____
Ilumya (tildrakizumab)	Initial Dose: ☐ 100mg SQ at weeks 0, 4 and every 12 weeks thereafter Maintenance Dose: ☐ 100mg SQ every 12 weeks	☐ 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 ☐ _____
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 orders: _____	☐ x1 year ☐ _____
☐ **Rituximab** or rituximab biosimilar (as required by patient's insurance) ☐ Do not substitute. Infuse the following rituximab product: _____	Initial Dose: ☐ 1000mg IV at day 0, 15 days Maintenance Dose: ☐ 500mg IV at month 12 and every 6 months thereafter Other dose: _____ For Paragon use only. Brand: _____ **Pre-med Orders**: Solu-Medrol 100mg IV, acetaminophen 1000mg PO, and diphenhydramine 50mg PO or IV	☐ x1 year ☐ _____
Simponi Aria (golimumab)	Initial Dose: ☐ 2mg/kg IV at weeks 0, 4 and then every 8 weeks Maintenance Dose: ☐ 2mg/kg IV every 8 weeks	☐ x1 year ☐ _____
Spevigo (spesolimab)	☐ 900mg IV x 1 ☐ Repeat Spevigo 900mg IV in 1 week if symptoms persist	None
☐ **Ustekinumab** or ustekinumab biosimilar (as required by patient's insurance) ☐ Do not substitute**.** Give the following ustekinumab product: _____	☐ 45mg SubQ initially and 4 weeks later, followed by 45mg every 12 weeks (≤ 100kg) ☐ 90mg SubQ initially and 4 weeks later, followed by 90mg every 12 weeks (>100kg) Maintenance Dosing: ☐ 45mg SQ every 12 weeks For Paragon use only. Brand:_____ ☐ 90mg SQ every 12 weeks	☐ x1 year ☐ _____
Xolair (omalizumab)	☐ 150mg ☐ 300mg ☐ _____mg SubQ every 4 weeks Note: Patient must have an EpiPen in their possession on their appointment date	☐ x1 year ☐ _____

Pre-medication orders: Acetaminophen ☐ 1000mg ☐ 500mg PO, please choose one antihistamine (if indicated):
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Cetirizine 10mg IVP
Additional pre-medications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other _____
Lab orders: _____ **Lab Frequency:** _____
☐ 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.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR DERMATOLOGY 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., 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., ustekinumab, 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

☐ TB screening test completed within 12 months - attach results

Required for: Cimzia, infliximab, ustekinumab, 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 - 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+)