PARAGON HEALTHCARE

A Carelon Company

RHEUMATOLOGY 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	Refill
Actemra	☐ 4 mg/kg IV every 4 weeks for _____ doses, then followed by 8mg/kg every 4weeks thereafter ☐ 4 mg/kg IV every 4 weeks ****Dose not to exceed 800mg in RA/CRS**** ☐ 8 mg/kg IV every 4 weeks ****Dose not to exceed 600mg in GCA**** ☐ Other dose: _____ mg IV every 4 weeks	
Cimzia	☐ Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks Maintenance Dose: ☐ 200mg subcutaneously Q 2 weeks **OR** ☐ 400mg subcutaneously Q 4 weeks	
Krystexxa	☐ 8mg IV every 2 weeks	
Immunoglobulin	☐ IV ☐ SubQ _____ gm/kg x _____ day(s) **OR** divided over _____ day(s) _____ mg/kg x _____ day(s) **OR** divided over _____ day(s) Frequency: Every _____ weeks or _____ Brand: _____ (Paragon to choose if not indicated)	
Orencia	Orencia Dose: _____ mg IV Frequency: ☐ Every 4 weeks OR ☐ 0, 2, 4 weeks, and every 4 weeks thereafter	
Simponi Aria	☐ Initial Dose: 2mg/kg at weeks 0, 4, and then every 8 weeks ☐ Maintenance Dose: 2mg/kg every 8 weeks	
Stelara	Initial Dose: ☐ 45mg subcutaneously initially, 4 weeks later, followed by 45mg every 12 weeks ☐ 90mg subcutaneously initially, 4 weeks later, followed by 90mg every 12 weeks Maintenance Dose: ☐ 45mg subcutaneously every 12 weeks Maintenance Dose: ☐ 90mg subcutaneously every 12 weeks	
Infliximab	Dose: _____ mg/kg Frequency: ☐ Every _____ weeks ☐ 0, 2, 6, then every 8 weeks ☐ May substitute biosimilar per insurance requirement ***For Paragon use***. Brand: _____ ☐ Do not substitute. Brand: _____	
Rituximab	Dose: ☐ 1000mg ☐ Other: _____ ☐ 375mg/m² Frequency: ☐ One time dose ☐ Weekly x4 weeks ☐ Day 0, repeat dose in 2 weeks ☐ May substitute biosimilar per insurance requirement ***For Paragon use***. Brand: _____ ☐ Do not substitute. Brand: _____	
Saphnelo	☐ 300mg IV every 4 weeks	

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 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 RHEUMATOLOGY THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROSSING & 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? ☐ 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

☐ *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: Actemra, Cimzia, infliximab, Stelara, Simponi Aria, Orencia

☐ Positive ☐ Negative

☐ Hepatitis B screening (Hepatitis B surface antigen) - ☐ Positive ☐ Negative
Required for: Actemra, 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 - attach results Required for: IVIG

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