



A Carelon Company

ALLERGY/IMMUNOLOGY INFUSION ORDERS

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: <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

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"/> Xolair 75mg SubQ <input type="checkbox"/> Xolair 150mg SubQ <input type="checkbox"/> Xolair 225mg SubQ <input type="checkbox"/> Xolair 300mg SubQ <input type="checkbox"/> Xolair 375mg SubQ <input type="checkbox"/> Xolair 450mg SubQ <input type="checkbox"/> Xolair 525mg SubQ <input type="checkbox"/> Xolair 600mg SubQ	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Xolair frequency: <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks	

<input type="checkbox"/> Cinqair 3mg/kg IV every 4 weeks <input type="checkbox"/> Fasenra (initial start): 30mg SubQ every 4 weeks for the first 3 doses followed by 30 mg SubQ every 8 weeks thereafter <input type="checkbox"/> Fasenra 30mg SubQ every 8 weeks <input type="checkbox"/> Nucala 100mg SubQ every 4 weeks <input type="checkbox"/> Nucala 300mg SubQ every 4 weeks <input type="checkbox"/> Tezspire 210mg SubQ every 4 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
---	---

Immunoglobulin: IV SubQ

_____ mg/kg OR _____ gm/kg x _____ day(s) OR divided over _____ day(s)

Frequency: Every _____ weeks OR _____

(Paragon to choose if not indicated) Brand: _____

Additional Ig orders: _____

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: _____

Required labs to be drawn by: Paragon Referring provider

As required by your state, Prescriber to check "Dispense as written" or handwritten "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:** _____

PATIENT INFORMATION

Name:

DOB:

REQUIRED PRE-SCREENING (BASED ON DRUG THERAPY)

- 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
 - Please indicate any tried and failed therapies (if applicable):
 - Corticosteroids _____
 - Long acting beta 2 agonist _____
 - Long acting muscarinic antagonist _____
 - Immunosuppressants (EGPA) _____
 - Asthma* - Does the patient have a history of 2 exacerbations requiring a course of oral/systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? Yes No
 - Asthma* - Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? Yes No
 - PI* - Documentation of recurrent bacterial infections, history of failure to respond to antibiotics, documentation of pre and post pneumococcal vaccine titers
- Include labs and/or test results to support diagnosis (**attach results**)
 - Does patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcL within the past 6 weeks (*asthma & EGPA*) or ≥ 1000 cells/mcL within 4 weeks (*HES*)? Yes No
 - FEV1 score (if applicable): _____
 - Serum IgE level - *for asthma & nasal polyps Xolair*
 - Skin/RAST test - *for asthma Xolair*
 - Serum immunoglobulins - *for Ig*
 - Serum creatinine - *for Ig*
 - CBC w/differential - *for Fasenna, Nucala, Cinqair*
- If injection order, is the patient or caregiver not competent or physically unable to administer the product for self-administration? Yes No
- Xolair - Patient has Epi pen prescribed
- Other medical necessity: _____