PARAGON HEALTHCARE

A Carelon Company

NEPHROLOGY 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
Crysvita (burosumab)	**Max dose 90mg** ☐ Adult XLH 1mg/kg subQ rounded to nearest 10mg, every 4 weeks ☐ Pediatric XLH 0.8 mg/kg subQ rounded to nearest 10mg, q 2 weeks Other dosage: _____, frequency _____	☐ x 1 year ☐ _____
Krystexxa (pegloticase)	☐ 8mg IV every 2 weeks **Pre-medication protocol:** Diphenhydramine 50mg IV/PO & Solu-Medrol 125mg IV ☐ Other orders: _____	☐ x 1 year ☐ _____
Rituximab IV	Dose: ☐ 1000mg ☐ 375mg/m^2 ☐ Other: _____ Frequency: ☐ One time dose ☐ Weekly x4 weeks ☐ Day 0, repeat dose in 2 weeks ☐ Other: _____ ☐ May substitute biosimilar per insurance. **For Paragon use** - Brand: _____ ☐ Do not substitute. Brand: _____ **Pre-medication protocol:** Diphenhydramine 50mg IV/PO & Solu-Medrol 100mg IV	☐ x 1 year ☐ _____
Immunoglobulin	☐ **IVIg** ☐ **SubQ** _____ gm/kg x _____ day(s) **OR** divided over _____ day(s) Brand: _____ _____ mg/kg x _____ day(s) **OR** divided over _____ day(s) (Paragon to choose if not indicated) **Frequency**: Every _____ weeks or _____ Additional Ig orders: _____	☐ x 1 year ☐ _____
*If the patient has Aetna, Cigna, Humana, or UHC, the patient must try and fail Venofer first		
Injectafer* (ferric carboxymaltose)	☐ 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt <50kg) ☐ 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt ≥50kg)	
Monoferric* (ferric derisomaltose)	☐ 20mg/kg IV x 1 dose (wt <50kg) ☐ 1000mg IV x 1 dose (wt ≥50kg)	
Venofer (iron sucrose)	☐ 200mg IV - Administer 5 doses over a 14 day period ☐ 200mg IV weekly x 5 doses	

Pre-medication orders: Acetaminophen ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Diphenhydramine 25-50mg PO/IV ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Cetirizine 10mg IVP

Additional pre-medications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP
☐ Other _____

Lab orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

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 NEPHROLOGY 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 current medication list

☐ **Supporting clinical notes (H&P) to support primary diagnosis - Including tried/failed therapies, intolerance, benefits, of 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)? _____

☐ Include labs and/or test results to support diagnosis

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ **Baseline serum uric acid & G6PD serum level (Krystexxa)**

☐ **CBC, iron, transferrin, ferritin, TIBC (iron)**

☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) (Rituxan)**

- ☐ Positive ☐ Negative

☐ **Serum phosphorus (Crysvita)**

☐ **Creatinine (Ig)**

*If Hep B results are positive - please provide documentation of treatment or medical clearance