

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	INFUSION ORDERS
<input type="checkbox"/> Dehydration (ICD-10 _____) <input type="checkbox"/> Gastroenteritis (ICD-10 _____) <input type="checkbox"/> Other: _____ (ICD-10 _____)	<input type="checkbox"/> 1 Liter / <input type="checkbox"/> 2 Liters D5 .45% NS IV x 1 <input type="checkbox"/> 1 Liter / <input type="checkbox"/> 2 Liters NS IV x 1 <input type="checkbox"/> 1 Liter / <input type="checkbox"/> 2 Liters LR IV x 1 <input type="checkbox"/> May repeat dose x _____ days
<input type="checkbox"/> Iron Deficiency Anemia (ICD-10 _____) <input type="checkbox"/> Iron Deficiency Anemia with CKD not on dialysis (ICD-10 _____)	<input type="checkbox"/> Venofer 200mg IV - Administer 5 doses over a 14 day period <input type="checkbox"/> Venofer 200mg IV weekly x 5 doses <input type="checkbox"/> Injectafer 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt <50kg) <input type="checkbox"/> Injectafer 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg (wt ≥50kg) <input type="checkbox"/> Monofer 20mg/kg IV x 1 dose (wt <50kg) <input type="checkbox"/> Monofer 1000mg IV x 1 dose (wt ≥50kg)
<input type="checkbox"/> Nausea/Vomiting (ICD-10 _____)	<input type="checkbox"/> Zofran 4mg IVP <input type="checkbox"/> Reglan 10mg IV <input type="checkbox"/> Zofran 8mg IVP
<input type="checkbox"/> Pneumonia (ICD-10 _____)	<input type="checkbox"/> Zithromax 500mg IV daily x 3 days <input type="checkbox"/> Ivanz 1mg IV daily x 7 days
<input type="checkbox"/> Chronic Sinusitis (ICD-10 _____)	<input type="checkbox"/> Rocephin 2gms IV daily x 14 days
<input type="checkbox"/> Chronic Bronchitis (ICD-10 _____)	<input type="checkbox"/> Zithromax 500mg IV daily x 3 days <input type="checkbox"/> Solu-Medrol 125mg IVP x 1 day, then 62.5 mg IVP x 2 days
<input type="checkbox"/> Pyelonephritis (ICD-10 _____) <input type="checkbox"/> Complicated UTI (ICD-10 _____)	<input type="checkbox"/> Rocephin 2gms IV daily x 7 days <input type="checkbox"/> Ivanz 1gm IV daily x 7 days
<input type="checkbox"/> Cellulitis/MSSA (ICD-10 _____) <input type="checkbox"/> Location: _____	<input type="checkbox"/> Rocephin 1gm IV daily x 7 days
<input type="checkbox"/> MRSA (ICD-10 _____) <input type="checkbox"/> Location: _____	<input type="checkbox"/> Cubicin 4mg/kg IV daily x _____ weeks <input type="checkbox"/> Cubicin 4mg/kg IV daily x 7 days <input type="checkbox"/> Cubicin _____
<input type="checkbox"/> Multiple Sclerosis Exacerbation (ICD-10 _____)	<input type="checkbox"/> Solu-Medrol 1gm IV daily for <input type="checkbox"/> 3 days <input type="checkbox"/> 5 days
<input type="checkbox"/> Migraines (ICD-10 _____)	<input type="checkbox"/> Depacon 500mg IV x 1 <input type="checkbox"/> DHE 45 1mg IV (must premed for nausea) <input type="checkbox"/> Zofran 4mg IVP, may repeat x 1 <input type="checkbox"/> Reglan 10mg IV x 1
<input type="checkbox"/> Other: _____ (ICD-10 _____)	<input type="checkbox"/> Magnesium Sulfate 1 gram IV x 1 <input type="checkbox"/> Solu-Medrol 125mg IVP x 1 <input type="checkbox"/> Toradol 30mg IVP x 1 <input type="checkbox"/> Repeat regimen x _____ days
<input type="checkbox"/> Other: _____ (ICD-10 _____)	<input type="checkbox"/> Other: _____

Lab orders: _____ **Lab Frequency:** _____

Required labs to be drawn by ☐ Paragon Healthcare ☐ 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:





A Carelon Company

COMPREHENSIVE SUPPORT FOR INFUSION 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 (H&P) to support primary diagnosis
 - ☐ For iron orders - Has the patient tried and failed or have a contraindication to oral iron? ☐ Yes ☐ No
- ☐ Labs
 - ☐ CPK (Cubicin order) - **(attach)** **can draw with first infusion if unavailable*
 - ☐ CBC, iron, Ferritin, Transferrin, TIBC (iron orders) - **(attach)**
 - ☐ LFTs (Depacon order) - **(attach)** **can draw with first infusion if unavailable*
- ☐ Culture results attached (if applicable)
- ☐ PICC/Central line placement confirmation (if applicable)
- ☐ Other medical necessity: _____

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

PARAGONHEALTHCARE.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.