

**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
Allergies:				
<b>Diagnosis Code ICD-10: (required)</b>			<b>Diagnosis Description:</b>	
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"/> <b>Xolair</b> 75mg SubQ <input type="checkbox"/> <b>Xolair</b> 150mg SubQ <input type="checkbox"/> <b>Xolair</b> 225mg SubQ <input type="checkbox"/> <b>Xolair</b> 300mg SubQ <input type="checkbox"/> <b>Xolair</b> 375mg SubQ <input type="checkbox"/> <b>Xolair</b> 450mg SubQ <input type="checkbox"/> <b>Xolair</b> 525mg SubQ <input type="checkbox"/> <b>Xolair</b> 600mg Sub-Q	<b>Xolair frequency:</b> <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<input type="checkbox"/> <b>Cinqair</b> 3mg/kg IV every 4 weeks  <input type="checkbox"/> <b>Fasenra</b> initial dose: 30mg SubQ every 4 weeks for the first 3 doses followed by 30 mg SubQ every 8 weeks thereafter <input type="checkbox"/> <b>Fasenra</b> 30mg SubQ every 8 weeks  <input type="checkbox"/> <b>Nucala</b> 100mg SubQ every 4 weeks <input type="checkbox"/> <b>Nucala</b> 300mg SubQ every 4 weeks  <input type="checkbox"/> <b>Tezspire</b> 210mg Sub-Q every 4 weeks		<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<input type="checkbox"/> <b>Prolastin</b> 60mg/kg IV weekly <input type="checkbox"/> <b>Glassia</b> 60mg/kg IV weekly		<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Other: _____		<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

<b>Lab orders:</b> _____ <b>Frequency:</b> <input type="checkbox"/> Every infusion <input type="checkbox"/> Other: _____ Required labs to be drawn by: <input type="checkbox"/> Paragon <input type="checkbox"/> Referring Provider
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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.

<b>Prescriber Signature: X</b>	<b>Date:</b>
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**PATIENT INFORMATION**

Name:

DOB:

**REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & 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
  - 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  $\geq 150$  cells/mcL within the past 6 weeks (asthma & EGPA) or  $\geq 1000$  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 IgA - for Prolastin, Glassia (contraindicated in IgA deficiency)
  - Alpha1-antitrypsin (AAT) level - for Prolastin, Glassia
  - CBC w/differential - for Fasenra, Nucala, Cinqair
- Injection order - Is the patient or caregiver competent for self-administration?  Yes  No  
Is the patient physically able to administer the product for self-administration?  Yes  No
- Xolair - Patient has Epi pen prescribed
- Other medical necessity: \_\_\_\_\_