PARAGON HEALTHCARE

A Carelon Company

INFLIXIMAB 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: ☐ 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	Frequency	Refills
☐ Infuse infliximab **OR** infliximab biosimilar IV *Preferred product TBD after benefits investigation (noted below) ☐ Do not substitute Infuse the following infliximab product IV: _____	☐ _____ mg/kg ☐ _____	☐ 0, 2, 6 weeks, and every 8 weeks thereafter ☐ every _____ weeks ☐ Other: _____	☐ x 1 year ☐ _____

Pre-Medication Orders: Acetaminophen ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO ☐ Cetirizine 10mg PO ☐ Cetirizine 10mg IV

Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IVP
☐ Solu-Cortef _____ mg IVP
☐ Other: _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____
☐ TB QFT Screening yearly (optional) ☐ Baseline HepBcAB total
Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

*FOR PARAGON USE ONLY

Drug/Brand Selection: _____

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 INFLIXIMAB 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 medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)? ☐ Yes ☐ No
  If yes, which drug(s)? _____
- ☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara, Cimzia)? ☐ Yes ☐ No
  If yes, which drug(s)? _____
- ☐ If psoriasis diagnosis, percent of body surface (BSA) involved: _____ %

☐ Include labs and/or test results to support diagnosis

☐ *If applicable* - Last known biological therapy: _____ and last date received: _____. If patient is switching biologic therapies, please perform a wash-out period of _____ weeks prior to starting infliximab

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ **TB screening test (completed within 12 months if a new start) - attach results**

- ☐ **Positive** ☐ **Negative**

☐ **Hepatitis B screening test completed (Hepatitis B antigen) - attach results**

- ☐ **Positive** ☐ **Negative**

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