



PARAGON
HEALTHCARE

A Carelon Company

**OB/GYN
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: <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:

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	Refill
Immunoglobulin	<input type="checkbox"/> IV <input type="checkbox"/> 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 _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
Intralipid 20%	Infuse IV: <input type="checkbox"/> 4mL <input type="checkbox"/> 8mL <input type="checkbox"/> 100mL <input type="checkbox"/> Other: _____ mL Dilute in: <input type="checkbox"/> 100mL NS <input type="checkbox"/> 250mL NS <input type="checkbox"/> Other _____ mL <input type="checkbox"/> No dilution *Dilution required for small Intralipid doses (i.e., 4mL, 8mL)* Infuse over: <input type="checkbox"/> 30-45 minutes <input type="checkbox"/> 60 minutes <input type="checkbox"/> 90 minutes <input type="checkbox"/> Other: _____ <input type="checkbox"/> For Intralipid 100mL doses, titrate per protocol (approximately 2 hours) Frequency: every _____ weeks OR _____ Special instructions: _____	<input type="checkbox"/> _____ doses <input type="checkbox"/> _____ months <input type="checkbox"/> _____
Monoferric (ferric derisomaltose)	<input type="checkbox"/> Patient weighing less than 50kg (110 lbs.) Dose: Monoferric 20mg/kg IV x 1 dose <input type="checkbox"/> Patient weighing 50kg (110 lbs.) or greater Dose: Monoferric 1000mg IV x 1 dose	

Premedication orders:

- Acetaminophen 500mg 1000mg PO
- Solu-Medrol _____ mg IVP
- Loratadine 10mg PO
- Normal Saline 500mL IV
- Diphenhydramine 25mg PO
- Diphenhydramine 25mg IV
- Cetirizine 10mg PO
- Cetirizine 10mg IVP
- Other: _____

Lab Orders: _____ **Lab frequency:** Each infusion Other: _____

Required labs to be drawn by Paragon Healthcare 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:



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COMPREHENSIVE SUPPORT FOR OB/GYN THERAPY

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 answer the following (as applicable):

- Is the patient currently undergoing in-vitro fertilization/intracytoplasmic sperm injection? Yes No
- Week gestation if currently pregnant: _____

- Include labs and/or test results to support diagnosis

Iron labs (Monoferric)

- Other medical necessity: _____