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

COMPREHENSIVE SUPPORT FOR OB/GYN 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

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: ____