PARAGON HEALTHCARE

A Carelon Company

ONCOLOGY ORDER FORM

oncology@paragonhealthcare.com

P: 855.505.2348 | **F:** 855.475.5865

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

ICD-10 code: _____ **Diagnosis**: _____

Allergies: _____

Weight: _____ **kg** Height: _____ inches

☐ Call for weight change greater than 10% from baseline

☐ No dose modifications required for any weight change

BSA: _____ m^2 *(if applicable)*

LAB ORDERS OR OTHER TESTS RELATED TO TREATMENT

☐ CBC w/plts, diff ☐ TSH ☐ LVEF done: _____/Ejection fraction: _____%

☐ CMP ☐ Creatinine ☐ Urine pregnancy test

☐ LFTs ☐ Renal Function ☐ Other: _____

Lab frequency: ☐ Prior to each cycle ☐ Other: _____ | Labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

HOLD PARAMETERS - PLEASE INDICATE

☐ No hold parameters for ANC/Platelets ☐ No hold parameters

☐ Hold and call for LFTs 3x ULN and/or Bili 1.5x ULN ☐ Hold and call for creatinine 1.5x ULN

☐ Hold and call for ANC: _____ /Platelets: _____

☐ Other hold parameters: _____

PRE-MED AND ANTIEMETIC ORDERS

☐ Zofran _____ mg IV ☐ Decadron _____ mg IV ☐ Benadryl _____ mg IV ☐ Pepcid _____ mg IV

☐ Reglan _____ mg IV ☐ Solu-Medrol _____ mg IV ☐ Benadryl _____ mg PO ☐ Tylenol _____ mg PO

☐ Granisetron _____ mg IV ☐ Hydration/other: _____ Frequency: ☐ PRN ☐ Standing order ☐_____

TREATMENT ORDER

**** All available drugs listed on Page 2****

Date/Day	Drug	Dosing (i.e., mg/kg)	Calculated Dose	Route	Frequency	Special Instructions *Volume, diluent, & rate set by Paragon unless otherwise noted here

Date of last infusion: _____ Cycle number: _____

Subsequent treatments may be given +/- _____ days

This order is good for _____ cycles from the date ordered. Next appointment with Oncologist: _____

Call referring provider for: _____

Oral treatment patient is on: _____

Other orders/information: _____

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: _____

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR ONCOLOGY THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Patient demographics including insurance information (copies of insurance cards preferred)
- ☐ Treatment orders - include drugs, dose, frequency, administration, and cycle definition
- ☐ Pre-medication orders (including glucocorticoids) - *if applicable*
- ☐ Supportive therapy orders (including anti-emetics, CSFs, hydration, antibiotics) - *if applicable*
- ☐ Note: oral prescriptions need to be filled at local pharmacy prior to infusion
- ☐ Monitoring and hold parameters
- ☐ Dose adjustment protocol, where applicable (i.e., weight changes, lab parameters)
- ☐ Standing orders (infusion reactions, management of CVC occlusion, etc.)
- ☐ Lab orders - if labs need to be drawn by Paragon
- ☐ Clinical chart notes within the last 12 months
- ☐ Recent lab results & diagnostic results
- ☐ Medication list, if available
- ☐ Date of last cycle or infusion dose
- ☐ Next follow-up visit with Oncologist

Oncology Therapies Available:

amivantamab
alvelumab
atezolizumab
atezolizumab& hyaluronidase
bevacizumab & biosimilars
cemiplimab
daratumumab & hyaluronidase
denosumab
dostarlimab
durvalumab
fulvestrant
goserelin acetate
ipilimumab
lantreotide
leuprolide acetate
mogamulizumab
nivolumab
nivolumab & relatimab
octreotide
pegfilgrastim
pembrolizumab
pertuzumab
pertuzumab/trastuzumab/hyaluronidase
rituximab & biosimilars
toripalimab
trastuzumab & biosimilars
tremelimumab
triptorelin pamoate

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) 475-5865 or call (855) 505-2348 for assistance