PARAGON HEALTHCARE

A Carelon Company

HYDRATION INFUSION ORDERS

P: 866.972.5888 | **F:** 866.491.5888

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 866.491.5888

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: _____ **ICD-10 Code:** _____

Height: _____ Weight: _____ Allergies: _____

Existing vascular access: _____

Central line* - Type: _____ Number of lumens: _____

**confirmation of placement documentation required for central lines*

THERAPY ORDER

Start of care: ☐ ASAP ☐ or _____

1. Please infuse _____ liters, over _____ hours

☐ Lactated Ringers ☐ D5 1/2 NS ☐ Normal Saline

☐ 1/2 NS ☐ D5LR ☐ D5NS

Frequency: ☐ Infuse _____ x a day

☐ Infuse _____ x per week

Regimen duration: ☐ 1 week ☐ 30 days ☐ 3 months ☐ 6 months ☐ Other: _____

☐ PRN until, date: _____

2. Please add the following additives to each bag prior to infusion:

☐ KCL _____ meq ☐ MVI 10mL ☐ Magnesium sulfate: ☐ 1 gm ☐ 2 gm ☐ _____ gm

☐ Famotidine _____mg ☐ Thiamine 100mg ☐ Folate 1mg

3. Include the following IVP medications:

☐ Zofran _____ mg IVP every ☐ 6 hours ☐ 8 hours PRN

☐ Promethazine _____ mg slow IVP every ☐ 4 hours ☐ 6 hours PRN

☐ Protonix 40mg IVP daily

4. Draw the following labs:

☐ CMP, Mag ☐ CBC ☐ BMP, Mag ☐ Phos ☐ Other: _____

Draw labs on _____ Fax labs to (866.491.5888)

(may draw labs the following morning if infusion started after 6pm, applicable to home patients)

Lab frequency: _____

5. Orders for vascular access (Paragon to set up Midline or PICC line placement through third-party company)

☐ PIV insertion by home health ☐ Arrange for Midline placement ☐ Arrange for PICC line placement

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: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

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

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COMPREHENSIVE SUPPORT FOR HYDRATION THERAPY

PATIENT INFORMATION:

Patient 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 (H&P) to support primary diagnosis
- ☐ Labs attached
- ☐ Vascular access information
  - ☐ Confirmation of central line placement (if applicable)
- ☐ Other medical necessity: _____

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 (866) 491-5888 or call (866) 866-972-5888 for assistance