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:

☐ Dehydration ☐ Gastroenteritis ☐ Nausea/Vomiting ☐ Electrolyte Imbalance

☐ Hyperemesis of Pregnancy ☐ POTS ☐ Other: _____

ICD-10 Code: _____ **Patient weight**: _____ lbs

THERAPY ORDER

Fluid:

☐ Normal Saline ☐ D5 1/2 NS ☐ 1/2 Normal Saline ☐ D5LR ☐ D5NS ☐ Lactated Ringers

☐ Other: _____

Volume:

☐ 1 Liter (1000mL)

☐ 2 Liter (2000mL)

☐ 500mL

☐ Other: _____

Frequency:

☐ One time dose _____

☐ _____ times per week

☐ Other: _____

Rate of Administration:

☐ Bolus, as tolerated

☐ Over 1 hour

☐ Over 2 hours

☐ Over _____ hours

Additional IV additive medications for infusion:

☐ **MVI** ☐ **Mag sulfate IV**: ☐ 1 gm ☐ 2 gm Other: _____

KCL IV: ☐ 20 meq IV ☐ 40 meq (infuse each 10meq over 1 hour)

Additional medications:

Zofran: ☐ 4mg IVP ☐ 8mg IV **Reglan:** ☐ 10mg IV **Pepcid:** ☐ 20mg IVP **Protonix:** ☐ 40mg IVP

Regimen duration (if > than one time dose): ☐ 1 week ☐ 30 days ☐ 3 months ☐ 6 months

☐ Other: _____ ☐ PRN until, date: _____

Lab Orders: _____ Frequency: ☐ One time ☐ Weekly ☐ Other: _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: _____

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 IV FLUID 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
  - ☐ Serum potassium (if order contains KCL)
- ☐ PICC/Central line placement confirmation (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 (855) 889-2946 or call (877) 365-5566 for assistance