PARAGON HEALTHCARE
A Carelon Company

TROGARZO INJECTION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

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

MEDICAL INFORMATION

Diagnosis: ☐ HIV (ICD-10 code: B20)
☐ Other: _____ (ICD-10 code: _____)

Diagnosis (secondary): ☐ Resistance to antiviral drug(s) (ICD-10 code: Z16.33)

Patient Weight: _____ lbs. Allergies: _____

THERAPY ORDER

Trogarzo (ibalizumab-uiyk)

Adult dosing:

☐ New start: 2000mg IV x 1 dose, then 800mg IV every 2 weeks

☐ 800mg IV every 2 weeks

Refill for: ☐ 6 months ☐ 12 months ☐ Other: _____

Lab Orders: _____ **Lab Frequency:** _____

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 TROGARZO 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 current medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to other therapy
  - ☐ Does the patient have multi-drug resistance HIV-1 infection? ☐ Yes ☐ No
  - ☐ Has the patient failed HAART therapy? ☐ Yes ☐ No
  - ☐ Please indicate ALL drug categories in which the patient is drug resistant:
    - ☐ Nucleoside reverse transcriptase inhibitors
    - ☐ Non-nucleoside reverse transcriptase inhibitors
    - ☐ Integrase strand transfer inhibitors
    - ☐ Protease inhibitors
    - ☐ Fusion inhibitors
    - ☐ CCR5-antagonists
- ☐ Include labs and/or test results to support diagnosis
  - ☐ Does the patient have a viral load > 1,000 copies/mL? ☐ Yes ☐ No **(attach results)**
- ☐ 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