PARAGON INFUSION CENTERS

ANTIBIOTICS INFUSION ORDER

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Patient Weight: _____ lbs. Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

DIAGNOSIS:

- ☐ Cellulitis/MSSA Location: _____
- ☐ Chronic Bronchitis _____
- ☐ Chronic Sinusitis _____
- ☐ Dehydration/Flu/Viral syndrome _____
- ☐ Diabetic Wound Location: _____
- ☐ Diverticulitis _____
- ☐ Gastroenteritis _____
- ☐ Pyelonephritis _____
- ☐ Other: _____
- ☐ MRSA Location: _____
- ☐ Pneumonia _____
- ☐ Complicated UTI _____
- ☐ Osteomyelitis Location: _____

ANTIBIOTIC IV ORDERS

- ☐ Avelox 400mg
- ☐ Baxdela ☐ 300mg ☐ Other: _____
- ☐ Cefazolin 1gm
- ☐ Cipro 400mg
- ☐ Clindamycin _____ mg
- ☐ Cubicin ☐ 4mg/kg ☐ 6mg/kg ☐ Baseline CPK and BMP
- ☐ Dalvance ☐ 100mg followed one week later by 500mg. ☐ 750 mg followed one week later by 375mg (CrCl < 30) ☐ 1500 mg x 1 dose ☐ 1125 mg x 1 dose (CrCl < 30)
- ☐ Flagyl 500mg
- ☐ Fortaz ☐ 1gm ☐ 2gm
- ☐ Gentamicin _____ mg
- ☐ Invanz 1g
- ☐ Levaquin _____ mg
- ☐ Maxipime ☐ 1gm ☐ 2gm
- ☐ Merrem _____ mg
- ☐ Nuzyra ☐ 200mg ☐ 100mg
- ☐ Orbactiv 1200mg
- ☐ Other: _____
- ☐ Primaxin ☐ 250mg ☐ 500mg
- ☐ Rocephin ☐ 1gm ☐ 2gm
- ☐ Tobramycin _____ mg
- ☐ Vancomycin (must have PICC line) ☐ 500mg ☐ 1000mg ☐ _____ mg *Vancomycin levels before 4th dose then trough weekly
- ☐ Vibativ ☐ 10mg/kg ☐ Other: _____
- ☐ Xerava _____ mg
- ☐ Zemdri ☐ 15mg/kg (CrCl ≥ 90) ☐ Other: _____ *CrCl must be monitored daily*
- ☐ Zithromax 500mg
- ☐ Zosyn 3. 375g

DOSING ☐ Daily or ☐ BID for _____ days _____ weeks

☐ Lab Orders: _____

☐ Additional Orders/Comments: _____

PHYSICIAN 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.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Phone: 877-365-5566 **Fax: 855-889-2946**	**Texas** ☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	**Tennessee** ☐ Knoxville	**Georgia** ☐ Atlanta

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