PARAGON INFUSION CENTERS

DERMATOLOGY ORDER FORM

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: _____

Diagnosis Date: _____ ICD-10: _____ ** Date of last: ☐ Orencia ☐ Remicade ☐ Humira ☐ Enbrel ☐ _____ ☐ Dose: _____

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

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

Lab Orders: _____

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required. (Cimzia, Remicade, Rituxan and Simponi Aria)

Hep B Labs: ☐ Hep B antigen attached ☐ Hep B Core antibody total attached ☐ Draw Hep B Labs

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. (Cimzia, Remicade, Stelara, and Ilumya)

TB Test: ☐ TB Test Attached ☐ Perform TB Testing

INJECTION AND INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐ Cellulitis ☐ MRSA ☐ Skin Infection/Abscess	☐ **Cubicin** ☐ 4mg/kg IV ☐ 6mg/kg IV ☐ Baseline CPK and BMP ☐ Daily for _____ days _____ weeks ☐ **Dalvance** ☐ 1000mg IV followed one week later by 500mg ☐ 750mg IV followed one week later by 375mg (CrCl<30) ☐ 1500mg IV x 1 dose ☐ 1125mg IV x 1 dose (CrCl<30) ☐ **Orbactiv** 1200mg IV ☐ **Rocephin** ☐ 1gm IV ☐ 2gm IV ☐ Daily for _____ days _____ weeks	
☐ Hypogammaglobulinemia ☐ Common Variable Immunodeficiency (CVID)	☐ **IVIG Orders:** _____ gm/kg IV divided over _____ day(s) _____ mg/kg IV divided over _____ day(s) Frequency: Every _____ weeks for one year OR _____ one time dose Protocol Pre-Medication Orders: ☐ Tylenol 1000mg PO Antihistamine: ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO Additional Pre-Medication Orders: ☐ Solu-Medrol _____ mg IV ☐ NS 0.9%. _____ mL IV	
☐ Chronic Idiopathic Urticaria	☐ **Xolair** ☐ 150mg SQ every 4 weeks ☐ 300mg SQ every 4 weeks **Date of last injection: _____ Note: Patient must have an EpiPen in their possession on their appointment date	
☐ Pemphigus Vulgaris	☐ **Rituxan** Initial Dose: ☐ 1000mg IV at 0, 15 days Maintenance: ☐ 500mg IV at month 12 and every 6 months thereafter Pre-Medication Orders: ☐ Tylenol 100mg PO and Benedryl 50mg PO/IV ☐ Solu-Medrol 100mg IV ☐ Other: _____ ☐ Prednisone Rx from referring provider	
☐ Psoriatic Arthritis ☐ Psoriasis ☐ Plaque Psoriasis	☐ **Remicade** _____ mg/kg IV every _____ weeks ☐ **Remicade** _____ mg/kg IV on weeks, 0, 2, 6 and then every 8 weeks Pre-Medication Orders: ☐ Tylenol 1000mg Antihistamine: ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO Additional Pre-Medication Orders: ☐ Solu-Medrol 62.5mg IV ☐ Solu-Medrol 125mg IV ☐ Solu-Cortef _____ mg IV ☐ **SimponiARIA** Initial Dose: ☐ 2mg/kg IV at weeks 0, 4 and then every 8 weeks Maintenance: ☐ 2mg/kg IV every 8 weeks ☐ **Solu-Medrol** 1gm IV daily x ☐ 3 days ☐ _____ days ☐ **Stelara** ☐ Patient weighing <100kg (220lbs.), 45mg SQ initially and 4 weeks later followed by 45mg every 12 weeks ☐ Patients weighing >100kg (220lbs.), 90mg SQ initially and 4 weeks later followed by 90mg every 12 weeks ☐ **Ilumya** Initial Dosing: ☐ 100mg SQ at weeks 0, 4 and every 12 weeks thereafter Maintenance: ☐ 100mg SQ every 12 weeks ☐ **Cimzia** ☐ Initial Dose: 400mg SQ at weeks 0, 2, and 4 ☐ Maintenance: ☐ 200mg SQ every 2 weeks OR ☐ 400mg SQ every 4 weeks ☐ Other _____ mg every 4 weeks	

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