



**PATIENT INFORMATION**

*Demographics attached*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**MEDICAL INFORMATION**

Diagnosis:  Hunter Syndrome ICD-10 Code: \_\_\_\_\_  
 Other: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

Patient Weight: \_\_\_\_\_ lbs.

Allergies: \_\_\_\_\_

Clinical/Progress Notes supporting primary diagnosis attached

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

**Lab Orders:** \_\_\_\_\_

**ELAPRASE ORDERS**

**Elaprase**  Dose: 0.5mg/kg IV every week  
 Other: \_\_\_\_\_ mg every \_\_\_\_\_

**Premedications:** Tylenol 1000mg PO and Benadryl 25mg PO to be given 30 minutes before infusion (if not contraindicated).

**\*\*Patient must bring own Epi Pen to each infusion.\*\***

**\*\*Once we receive all necessary documentation, we will schedule the patient's treatment.**

**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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