

PATIENT INFORMATION
 Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

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

 Diagnosis: Familial Hypercholesterolemia ICD-10 Code: E78.01
 Other _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

 Clinical/ Progress note, labs, and test supporting primary diagnosis attached

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

Lab Orders: _____

EVKEEZA ORDERS
 15mg/kg IV every 4 weeks

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

<input type="checkbox"/> Alpharetta, GA	<input type="checkbox"/> Arlington, TX	<input type="checkbox"/> Atlanta, GA	<input type="checkbox"/> Austin, TX	<input type="checkbox"/> Clear Lake, TX	<input type="checkbox"/> Dallas, TX	<input type="checkbox"/> Decatur, GA	<input type="checkbox"/> Fort Worth, TX
<input type="checkbox"/> Hendersonville, TN	<input type="checkbox"/> Houston, TX	<input type="checkbox"/> Knoxville, TN	<input type="checkbox"/> Kyle, TX	<input type="checkbox"/> Nashville, TN	<input type="checkbox"/> North Hills, TX	<input type="checkbox"/> Plano, TX	<input type="checkbox"/> Round Rock, TX
<input type="checkbox"/> San Antonio, TX	<input type="checkbox"/> Smyrna, GA	<input type="checkbox"/> Stone Oak, TX	<input type="checkbox"/> West Houston, TX	<input type="checkbox"/> The Woodlands, TX			

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