PARAGON
INFUSION CENTERS

EVKEEZA
INFUSION ORDERS
Phone: 877-365-5566 | Fax: 855-889-2946

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

☐ Alpharetta, GA	☐ Arlington, TX	☐ Atlanta, GA	☐ Austin, TX	☐ Clear Lake, TX	☐ Dallas, TX	☐ Decatur, GA	☐ Fort Worth, TX
☐ Hendersonville, TN	☐ Houston, TX	☐ Knoxville, TN	☐ Kyle, TX	☐ Nashville, TN	☐ North Hills, TX	☐ Plano, TX	☐ Round Rock, TX
☐ San Antonio, TX	☐ Smyrna, GA	☐ Stone Oak, TX	☐ West Houston, TX	☐ The Woodlands, TX			