



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, Infliximab)

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, Infliximab, Stelara, and Entyvio)

TB test: TB Test Attached Perform TB testing

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
<input type="checkbox"/> Dehydration <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Diverticulitis	<input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters D5 .45% NS IV x 1 day <input type="checkbox"/> 1 Liter <input type="checkbox"/> 2 Liters NS IV x 1 day <input type="checkbox"/> Cipro 400mg IV daily x 1 day <input type="checkbox"/> Flagyl 500mg IV daily x 5 days <input type="checkbox"/> Invanz 1gm IV daily x 1 day	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
<input type="checkbox"/> Iron Deficiency Anemia <input type="checkbox"/> Iron Deficiency Anemia with CKD not on dialysis Required Recent Labs: CBC, Ferritin, Iron Studies	<input type="checkbox"/> Venofer 200mg IV q 3 weeks x 5 doses <input type="checkbox"/> Venofer 100mg IV q week x 7 weeks then every other week x 7 weeks (10 doses total) <input type="checkbox"/> Venofer 200mg IV- Administer 5 doses over a 14 day period <input type="checkbox"/> Venofer 200mg IV weekly x 5 weeks <input type="checkbox"/> Injectafer 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg <i>if patient weighing less than 50kg (110lbs)</i> <input type="checkbox"/> Injectafer 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg <i>if patient weighing 50kg (110lbs) or greater</i>	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Cimzia 400mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks <input type="checkbox"/> Cimzia _____ mg Sub-Q every _____ weeks <input type="checkbox"/> Infliximab Brands available: <input type="checkbox"/> Inflectra <input type="checkbox"/> Remicade <input type="checkbox"/> Renflexis Dose: _____ mg/kg Frequency <input type="checkbox"/> Every _____ weeks OR <input type="checkbox"/> 0, 2, 6 then every 8 weeks Pre-medication Orders <input type="checkbox"/> Tylenol 1000mg Antihistamine <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Diphenhydramine 25 mg <input type="checkbox"/> Loratadine 10 mg PO Additional Pre-Medication Orders: <input type="checkbox"/> Solu Medrol 62.5mg IVP <input type="checkbox"/> Solu-Medrol 125mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP <input type="checkbox"/> Stelara initial infusion: <input type="checkbox"/> <55kg 260mg IV over 1 hour x 1 dose <input type="checkbox"/> 55kg to 85kg 390mg IV over 1 hour x 1 dose <input type="checkbox"/> >85kg 520 mg IV over 1 hour x 1 dose <input type="checkbox"/> Stelara maintenance: <input type="checkbox"/> 90mg SQ 8 weeks after initial infusion and then every 8 weeks. <input type="checkbox"/> Tysabri 300mg IV every 4 weeks <input type="checkbox"/> JCV antibody <input type="checkbox"/> Patient TOUCH authorization <input type="checkbox"/> Entyvio 300mg IV over 30 minutes at 0, 2, 6 weeks and then Q8 weeks (baseline LFTs) <input type="checkbox"/> Entyvio 300mg IV every 8 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year

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