PARAGON
INFUSION CENTERS

HIZENTRA 20%
INFUSION ORDERS

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

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

MEDICAL INFORMATION

Diagnosis: ☐ Primary Immunodeficiency ICD-10 Code: _____

☐ Chronic Inflammatory Demyelinating Polyneuropathy ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs. Allergies: _____

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

☐ **Required Labs:** Renal function (Cr, BUN)

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

Lab Orders: _____

HIZENTRA INFUSION ORDERS

PRIMARY IMMUNODEFICIENCY DOSING

☐ Weekly Dosing:

- Start one week after IVIG infusion
- _____ grams subQ weekly

☐ Biweekly Dosing (every 2 weeks):

- Start 1 or 2 weeks after the last IVIG Infusion or 1 week after the last weekly IGSC infusion
- _____ grams subQ every 2 weeks

☐ Frequent dosing (2 to 7 times per week):

- Start 1 week after last IVIG or IGSC infusion
- _____ grams subQ _____ days per week

CIPD DOSING

☐ Weekly Dosing:

- Initiate therapy 1 week after the last IVIG infusion
- _____ grams subQ weekly

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

PARAGONHEALTHCARE.COM