



To be administered in Home Infusion Center

PATIENT INFORMATION

Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

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

MEDICAL INFORMATION

Diagnosis: _____ ICD-10: _____

Patient Weight: _____ lbs. (REQUIRED) Allergies: _____

Clinical/Progress Notes, Labs (BMP), Tests supporting primary diagnosis attached

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

Lab Orders: _____

IMMUNOGLOBULIN ORDERS

IG Orders: IV Sub Q 5% 10% _____%

_____ gm/kg IV divided over _____ day(s)

_____ mg/kg IV divided over _____ day(s)

Frequency: Every _____ weeks for one year *or* _____ one time dose

Protocol Pre-Medication Orders: Tylenol 1000mg PO, please choose one antihistamine:

Cetirizine 10mg PO

Diphenhydramine 25mg PO

Loratadine 10mg PO

Additional Pre-Medication Order: Solu-Medrol _____ mg IVP NS 0.9 _____ mL IV

Additional Orders/Comments:

Brands Available: Flebogamma 5% (J1572) Flebogamma 10% (J1572) Gammagard (J1569)

Hizentra (J1559)

HyQvia (J1575)

Octagam 5% (J1568)

Octagam 10% (J1568)

Panzyga (J1599)

Privigen (J1459)

Availability may vary due to allocations and out of stock brands. Currently, our only non-allocated brand is Panzyga. For more information on availability, please contact your local Account Executive.

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