INFUSION ORDER FORM

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: __________

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

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

Lab Orders: ______________________

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS
☐ Dehydration (ICD-10 ________) ☐ Gastroenteritis (ICD-10 ________) ☐ Diverticulitis (ICD-10 ________)	☐ 1 Liter/ ☐ 2 Liters D5 .45% NS IV x 1 day ☐ 1 Liter/ ☐ 2 Liters NS IV x 1 day ☐ **Cipro** 400mg IV daily x 1 day ☐ **Flagyl** 500mg IV daily x 5 days ☐ **Invanz** 1gm IV daily x 1 day ☐ **Rocephin** 1gm IV daily x 7 days
☐ Iron Deficiency Anemia (ICD-10 ________) ☐ Iron Deficiency Anemia with CKD not on dialysis (ICD-10 ________)	☐ **Venofer** 200mg IV q 3 weeks x 5 doses ☐ **Venofer** 100mg IV q week x 7 weeks then every other week x 7 weeks ☐ **Venofer** 200mg IV - Administer 5 doses over a 14 day period ☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg *-if patient weighing less than 50kg (11lbs.)* ☐ **Injectafer** 750mg IV -Give 2 doses at least 7 days apart not to exceed 1500mg *-if patient weighing 50kg (110lbs.) or greater*
☐ Nausea/Vomiting (ICD-10 ________)	☐ **Zofran** 4mg slow IVP ☐ **Reglan** 10mg IV/100mL NS over 20 minutes ☐ **Zofran** 8mg slow IVP
☐ Pneumonia (ICD-10 ________)	☐ **Zithromax** 500mg IV daily x 3 days ☐ **Invanz** 1gm IV daily x 7 days
☐ Chronic Sinusitis (ICD-10 ________)	☐ **Rocephin** 2gms IV daily x 14 days ☐ **Invanz** 1gm daily x 14 days
☐ Chronic Bronchitis (ICD-10 ________)	☐ **Zithromax** 500mg IV daily x 3 days ☐ **Solu-Medrol** 125mg IVP x 1 day, then 62.5 mg IVP x 2 days
☐ Pyelonephritis (ICD-10 ________) ☐ Complicated UTI (ICD-10 ________)	☐ **Rocephin** 2gms IV daily x 7 days ☐ **Invanz** 1gm IV daily x 7 days
☐ Cellulitis/MSSA (ICD-10 ________) ☐ Location: ________	☐ **Rocephin** 1gm IV daily x 7 days
☐ MRSA (ICD-10 ________) ☐ Location: ________	☐ **Cubicin** 4mg/kg IV daily x 6 weeks ☐ **Cubicin** 6mg/kg IV daily x 7 days ☐ **Baseline BMP** ________
☐ Osteomyelitis (ICD-10 ________) ☐ Location: ________	☐ **Rocephin** 2gms IV daily x 6 weeks ☐ **Cubicin** 6mg/kg IV daily x 7 days ☐ **Cubicin** 4mg/kg IV daily x 6 weeks ☐ **Baseline BMP** ________
☐ Multiple Sclerosis Exacerbation (ICD-10 ________)	☐ **Solu-Medrol** 1gm IV daily ☐ 3 days ☐ 5 days ☐ **Zofran** 4-8mg slow IVP ☐ **Reglan** 10mg IV/100mL NS over 20min
☐ Migraines (ICD-10 ________)	☐ **Depacon** 500mg IV/250mLs NS ☐ **Magnesium Sulfate** 1gm IV/250mL NS ☐ **DHE** 45 1mg IV/100mL NS (must premed for nausea) ☐ **Solu-Medrol** 125mg ☐ **Zofran** 4mg IVP may Repeat x 1 ☐ **Toradol** 30mg IVP

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

	Texas	Tennessee	Georgia
Phone: 877-365-5566 **Fax: 855-889-2946**	☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	☐ Knoxville	☐ Atlanta

PARAGONHEALTHCARE.COM

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