PARAGON INFUSION CENTERS

NEUROLOGY 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 Name: __________ lbs. Allergies: ______________________

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached
☐ Last MRI documentation attached
☐ Patient's TOUCH authorization (only for Tysabri orders)
☐ Hepatitis B antigen and Hepatitis B Core total antibody required (only for Ocrevus orders)

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

Lab Orders: ______________________

INFUSION ORDERS

☐ Migraines
ICD-10: __________

Pre-Medication:

☐ Zofran 4mg slow IVP ☐ Zofran 8mg IVP ☐ Pepcid IV 20mg IVP ☐ Toradol 30mg IVP
☐ Solu-Medrol 125mg IVP ☐ Reglan 10mg IV/100mL NS over 20 minutes

Protocol:

☐ Depacon ☐ 500mg ☐ 750mg IV in 250mL NS
☐ Magnesium Sulfate 1gm IV in 250mL
☐ DHE 45 ☐ 0.5mg ☐ 1mg IV in 100mL NS *(must premed for nausea)*

Standing PRN Order: ☐ 1 month ☐ 2 months ☐ 3 months Repeat regimen daily for ________ days

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☐ Migraines
ICD-10: __________

Vyepti: ☐ 100mg IV every 3 months
☐ 300mg IV every 3 months

☐ Multiple Sclerosis Exacerbation
ICD-10: __________

☐ Solu-Medrol 1gm IV daily x ________ days
☐ Solu-Cortef 1gm IV daily x ________ days

☐ Multiple Sclerosis
ICD-10: __________

☐ Tysabri 300mg IV every 4 weeks (after registering patient with TOUCH)
Pre-medication protocol: Tylenol 1000mg PO and Benadryl 25mg PO
☐ Ocrevus ☐ 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months
☐ 600mg IV every 6 months
Pre-Medication Protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO to be given 30 minutes before infusion

IVIG ORDERS

Diagnosis: ______________________ ICD-10: __________ IVIG Brand ______________________

IVIG Orders: __________ mg/kg OR __________ gm/kg IV divided over ________ day(s)

Frequency: Every __________ weeks 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 Orders: ☐ Solu-Medrol __________ mg - 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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