



PATIENT INFORMATION

Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

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

MEDICAL INFORMATION

Diagnosis: Multiple Sclerosis (ICD-10 Code: _____)
 Relapsing-Remitting Primary-Progressive
 Secondary-Progressive Progressive-Relapsing

Patient Weight: _____ lbs.

Allergies: _____

- Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached
- Hepatitis B surface antigen and Hepatitis B Core total antibody required
- Last MRI

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

Lab Orders: _____

OCREVUS ORDERS

Ocrevus **Loading Dose:** 300mg IV at 0 and 2 weeks, then 600mg IV every 6 months
 Subsequent Dose: 600mg IV every 6 months

Protocol Pre-Medication Orders: Solu-medrol 100mg IV and Benedryl 25mg PO to be given 30 minutes before infusion

****Date of last** Rebif Betaseron Avonex Tysabri dose: _____

Additional Orders/Comments:

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

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