PARAGON INFUSION CENTERS

OSTEOPOROSIS ORDER FORM

Phone: 877-365-5566 | Fax: 855-889-2946

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

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

MEDICAL INFORMATION

Diagnosis: ☐ Senile Osteoporosis _____ ☐ Paget's disease of bone _____

☐ Glucocorticoid-induced osteoporosis _____

Patient Weight: _____ lbs. Allergies: _____

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

☐ Dexa Scan (-2.5 T score or more severe) ***if no -2.5 T score, please send history of fracture documentation*

☐ Labs: Prolia - Calcium within 6 months, CrCl if CKD;ZA - CMP/BMP within 60 days, Evenity - Calcium within 6 months

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

Lab Orders: _____

Tried & Failed Medications:

☐ Fosamax: Duration: _____ Reason for Discontinuing: _____

☐ Boniva: Duration: _____ Reason for Discontinuing: _____

☐ Actonel: Duration: _____ Reason for Discontinuing: _____

☐ Evista: Duration: _____ Reason for Discontinuing: _____

☐ Prolia: Duration: _____ Reason for Discontinuing: _____

ZOLEDRONIC ACID

J Code: J3489 Patient Weight: _____ lbs.

*Patient is currently taking calcium/vitamin D supplementation ☐ YES ☐ NO ☐ Other

☐ Zoledronic Acid 5mg/100mL IV once yearly

PROLIA SUB Q

J Code: J0897 Patient Weight: _____ lbs.

*Patient is currently taking calcium/vitamin D supplementation ☐ YES ☐ NO ☐ Other

☐ Prolia 60mg subcutaneous injection every 6 months *Date of last Prolia injection: _____

EVENITY SUB Q

J Code: J3111

*Patient is currently taking calcium/vitamin D supplementation ☐ YES ☐ NO ☐ Other Patient Weight: _____ lbs.

☐ Evenity 210mg subcutaneous injection once monthly

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

☐ Alpharetta, GA	☐ Arlington, TX	☐ Atlanta, GA	☐ Austin, TX	☐ Clear Lake, TX	☐ Dallas, TX	☐ Decatur, GA	☐ Fort Worth, TX
☐ Hendersonville, TN	☐ Houston, TX	☐ Knoxville, TN	☐ Kyle, TX	☐ Nashville, TN	☐ North Hills, TX	☐ Plano, TX	☐ Round Rock, TX
☐ San Antonio, TX	☐ Smyrna, GA	☐ Stone Oak, TX	☐ West Houston, TX	☐ The Woodlands, TX			