PARAGON
INFUSION CENTERS

PULMONARY 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: ________________

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

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

Lab Orders: ________________

FASENRA INJECTION

☐ **Severe Asthma with Eosinophilic phenotype** (ICD-10 ________)

Fasenra Initial Dose: ☐ 30mg subcutaneously every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter

Fasenra Maintenance Dose: ☐ 30mg subcutaneously every 8 weeks

XOLAIR INJECTION

☐ Allergic Asthma (ICD-10:) ________ ☐ ________________

Xolair Dose: ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg **Frequency**: Subcutaneously every: ☐ 2 weeks or ☐ 4 weeks

History: Positive Skin or RAST Test: ☐ Yes ☐ No Test date: ________
Pre-Treatment IgE Serum: ________ IU/mL Test date: ________

**** Date of last Xolair Injection:** ________ *Note: Patient must have an EpiPen in their possession with every appointment.*

PROLASTIN INFUSION

☐ **Alpha-1 Antitrypsin Deficiency (ICD-10** ________ **)** ☐ **Panacinar Emphysema (ICD-10** ________ **)**

Prolastin Dose: ☐ 60mg/kg IV weekly OR ☐ Other: ________________

Premedication: ________________

**** Date of last Prolastin Infusion:** ________

GLASSIA INFUSION

☐ **Alpha-1 Antitrypsin Deficiency (ICD-10** ________ **)**

Glassia Dose: ☐ 60mg/kg IV weekly **OR** ☐ Other: ________________

**** Date of last Glassia Infusion:** ________

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

	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

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