PARAGON
INFUSION CENTERS

RADICAVA (EDARAVONE)
INFUSION ORDERS

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: ____________________ DOB: ________ Phone: ____________

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

MEDICAL INFORMATION

Diagnosis: ☐ Amyotrophic Lateral Sclerosis (ALS) ICD-10 Code: ________

☐ Other: ____________________ ICD-10 Code: ________

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: ____________________

RADICAVA ORDERS

☐ **Initial Treatment Cycle:** 60mg IV daily for 14 days followed by 14-day drug free periods

☐ **Subsequent Dosing:** 60mg IV daily for 10 days out of 14-day periods, followed by 14 day drug free periods x 1 year

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

PARAGONHEALTHCARE.COM

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