

### PATIENT INFORMATION

 *Demographics attached*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

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

### MEDICAL INFORMATION

Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

Patient Weight: \_\_\_\_\_ lbs.

Allergies: \_\_\_\_\_

 Clinical/ Progress note, labs, and test supporting primary diagnosis attached

 SLE Disease Activity Index 2000 score \_\_\_\_\_

 Physician's Global Assessment score \_\_\_\_\_

Tried and failed medications: \_\_\_\_\_

Lab Orders: \_\_\_\_\_

### SAPHNELO ORDERS

 300mg IV every 4 weeks

**\*\* Once we receive all necessary documentation, we will schedule the patient's treatment.**

### 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

<input type="checkbox"/> Alpharetta, GA	<input type="checkbox"/> Arlington, TX	<input type="checkbox"/> Atlanta, GA	<input type="checkbox"/> Austin, TX	<input type="checkbox"/> Clear Lake, TX	<input type="checkbox"/> Dallas, TX	<input type="checkbox"/> Decatur, GA	<input type="checkbox"/> Fort Worth, TX
<input type="checkbox"/> Hendersonville, TN	<input type="checkbox"/> Houston, TX	<input type="checkbox"/> Knoxville, TN	<input type="checkbox"/> Kyle, TX	<input type="checkbox"/> Nashville, TN	<input type="checkbox"/> North Hills, TX	<input type="checkbox"/> Plano, TX	<input type="checkbox"/> Round Rock, TX
<input type="checkbox"/> San Antonio, TX	<input type="checkbox"/> Smyrna, GA	<input type="checkbox"/> Stone Oak, TX	<input type="checkbox"/> West Houston, TX	<input type="checkbox"/> The Woodlands, TX			

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