PARAGON
INFUSION CENTERS

VPRIV

(VELAGLUCERASE ALFA FOR INJECTION)

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: ☐ Gaucher Disease 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: ______________________

VPRIV ORDERS

☐ Dose: 60U/kg IV administered every two weeks as a 60 minute infusion

☐ Other: __________ U IV every two weeks as a 60 minute infusion

Pre-Medications (optional):

☐ Acetaminophen __________ mg PO before infusion (optional)

☐ Diphenhydramine __________ mg PO/IV before infusion (optional)

☐ Solu-medrol __________ mg IV before infusion (optional)

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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