

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: _____

INFUSION ORDERS

| DIAGNOSIS | INFUSION ORDERS | REFILLS |
|---|---|---|
| <input type="checkbox"/> Hyperemesis _____ | <input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters D5 .45% NS IV x 1 day <input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters NS IV x 1 day <input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters Ringers Lactate IV x 1 day <input type="checkbox"/> 1 Liter/ <input type="checkbox"/> 2 Liters D5/Ringers Lactate x 1 <input type="checkbox"/> Zofran 4mg IV <input type="checkbox"/> Zofran 8mg IV | <input type="checkbox"/> _____ <input type="checkbox"/> x 1 year |
| Primary ICD-10 <input type="checkbox"/> Iron Deficiency Anemia: _____ <input type="checkbox"/> Iron Deficiency Anemia with CKD not on dialysis _____ <input type="checkbox"/> Other medical necessity: _____ Required Recent Labs: HGB, HCT, TIBC, Ferritin | Last Iron dose (if applicable) _____ Secondary ICD-10 <input type="checkbox"/> Adverse Effect of other drug _____ (<i>Oral iron intolerance or not adequate</i>) <input type="checkbox"/> Other medical necessity: _____ <input type="checkbox"/> Venofer 200mg IV q 3 weeks x 5 doses <input type="checkbox"/> Venofer 100mg IV q week x 7 weeks then every other week x 7 weeks (10 doses total) <input type="checkbox"/> Venofer 200mg IV - Administer 5 doses over a 14 day period <input type="checkbox"/> Venofer 200mg IV weekly x 5 weeks <input type="checkbox"/> Injectafer 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg <i>if patient weighing less than 50kg (110lbs.)</i> <input type="checkbox"/> Injectafer 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg <i>if patient weighing 50kg (110lbs.) or greater</i> | <input type="checkbox"/> _____ <input type="checkbox"/> x 1 year |
| <input type="checkbox"/> Pyelonephritis _____ <input type="checkbox"/> Complicated UTI _____ Required Labs: CBC, BMP | <input type="checkbox"/> Rocephin 1gm IV daily x 7 days <input type="checkbox"/> Rocephin 2gms IV daily x 7 days <input type="checkbox"/> Invanz 1gm IV daily x 7 days | <input type="checkbox"/> _____ <input type="checkbox"/> x1 year |
| <input type="checkbox"/> Migraines: _____ Required Labs: LFTs if ordering Depacon treatment | <input type="checkbox"/> Zofran 4mg IV <input type="checkbox"/> Zofran 8mg IV <input type="checkbox"/> Reglan 10mg IV <input type="checkbox"/> Magnesium Sulfate 1gm IV <input type="checkbox"/> Depacon 500mg IV <input type="checkbox"/> DHE 45 1mg IV | <input type="checkbox"/> _____ <input type="checkbox"/> x1 year |

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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