PH: 888-588-1072
FAX: 866-388-1488
ParagonSpecialty.com

PARAGON SPECIALTY

BAXDELA
Order Form

PATIENT INFORMATION ☐ *demographics attached*

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Address: _____ Patient SSN: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email: _____ Alt. Phone: _____

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

REQUIRED DOCUMENTATION CHECKLIST

In order for our specialty team to process referrals and complete prior authorizations on behalf of your office, please include the following documents with each referral:

- ☐ Patient demographics page
- ☐ Copies of insurance cards (pharmacy and/or medical)
- ☐ Relevant clinical chart notes (including medications the patient has tried and failed
- ☐ Lab results *(if available)*

MEDICAL INFORMATION

Diagnosis Date: _____/_____/ _____ Weight: _____ Height:_____ Allergies :_____

ICD-10 CODE:_____ Has the patient received IV Baxdela? _____ Date Received:_____

History of Therapies Tried/Failed (Please Include Dates):_____

_____

PRESCRIPTION INFORMATION

☐ New ☐ Refill Needs by: ____/____/_____ Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other: _____

DRUG	DIRECTIONS	QUANTITY	REFILLS
BAXDELA® 450 MG Tab (DELAFLOXACIN)	☐ Take 1 tablet by mouth every 12 hours for _____ days. ☐ Please automatically triage patient to Paragon infusion center or set up home infusion if oral tablets are not approved through pharmacy benefits.		
BAXDELA® 300 MG Vial (DELAFLOXACIN)	☐ Infuse 300 mg intravenously every 12 hours over 60 minutes for _____ days. ☐ Infuse 200 mg intravenously every 12 hours over 60 minutes for _____ days (Renally adjusted dose, eGFR 15-29)		

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 designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____ Tax ID: _____

NPI: _____ DEA: _____ License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Contact Person: _____