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





	PA	TIENT INFORMATION	demographics at	tached	
Patient Name:			DOB: Sex:		
Address:			Patient SSN:		
City:	State:	Zip:	Phone:		
Email:			Alt. Phone:		
INSURANCE INFORM	ATION: PLEASE ATTACH	COPY OF PRESCRIPTIC	N/MEDICAL CARD(S), F	RONT AND BA	4 <i>CK</i>
	REQUIRED [DOCUMENTATION CHE	CKLIST		
In order for our specialty to include the following docu		nd complete prior autho	rizations on behalf of yo	ur office, pleas	se
	e cards (pharmacy and/or rart notes (including medical		ied and failed		
	MEI	DICAL INFORMATION			
Diagnosis Date:/	/ Weigl	ht: Height:	Allergies :		
ICD-10 CODE: Has the patient received IV Baxdela? Date Received:					
History of Therapies Tried	/Failed (Please Include Da	tes):			
	PRESC	CRIPTION INFORMATION	V		
□ New □ Refill Needs b		CRIPTION INFORMATION ip to: □ Patient's Home □ De			
□ New □ Refill Needs b DRUG				QUANTITY	REFILLS
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	y:// Sh Take 1 tablet by mout	ip to: Patient's Home Directions th every 12 hours for	octor's Office Other: days. n infusion center or set	QUANTITY	REFILLS
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