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

PARAGON SPECIALTY

DERMATOLOGY
Order Form

PATIENT INFORMATION ☐ *Demographics attached*

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

Address: _____ Patient SSN: _____

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

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

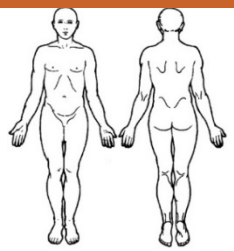
MEDICAL INFORMATION

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

ICD-10 Code: _____ Allergies: _____

☐ Psoriatic Arthritis ☐ Atopic Dermatitis/Eczema
☐ Mod to Sev Plaque Psoriasis
☐ Other: _____

TB/PPD Test given or intended to be given before start date? ☐ YES ☐ NO



Location: ☐ Hands ☐ Nails ☐ Feet ☐ Scalp ☐ Groin ☐ Other:
% BSA: _____

Tried & Failed Medications:

☐ Biologics ☐ Cimzia ☐ Enbrel ☐ Humira ☐ Orencia ☐ Remicade ☐ Rituxan ☐ Simponi ☐ Stelara
☐ MTX Soriatane CYA Duration: _____ Reason for Discontinuing: _____
☐ PUVA/UVB Duration: _____ Reason for Discontinuing: _____
☐ Topicals Duration: _____ Reason for Discontinuing: _____
☐ Contraindicated Medication: _____ Reason _____

PRESCRIPTION INFORMATION

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

DRUG		DIRECTIONS	QUANTITY	REFILLS
☐ Dupixent®	☐ 300mg Syringe	☐ Starter dose: Inject 2 syringes (600mg) on day 1 then 1 syringe (300mg) every other week thereafter. ☐ Maintenance dose: Inject 1 syringe (300mg) every other week.	4 week supply	
☐ Enbrel®	☐ 50mg Sureclick ☐ 50mg Prefilled Syringe ☐ 25mg Prefilled Syringe ☐ 25mg Vials	☐ Inject 50mg subcutaneously TWICE a week 72-96 hours apart. ☐ Inject 50mg subcutaneously ONCE a week. ☐ Inject 25mg subcutaneously TWICE a week 72-96 hours apart. ☐ Inject 2-25mg (50mg) on same day TWICE a week 72-96 hours apart.	4 week supply	
☐ Humira® ☐ Humira® - Citrate Free	☐ Psoriasis Starter Kit ☐ 40mg Pen ☐ 40mg Prefilled Syringe ☐ Hidradenitis Suppurative Starter Kit	☐ Inject (80mg) on Day 1, then 40mg on Day 8, then 40mg every other week. ☐ Inject (160 mg) on Day 1, then (80mg) on Day 15, then 40mg every week. ☐ Inject 40mg subcutaneously **EVERY OTHER** week. ☐ Inject 40mg subcutaneously **ONCE** a week.	Loading Dose 4 week supply	None _____
☐ Otezla®	☐ Starter Pack ☐ 30mg Tablets	☐ Titration: Take 1 tablet on day 1 then twice daily as directed ☐ Take 1 tablet by mouth twice daily ☐ Bridge Rx: Take 1 tablet by mouth twice daily; dispensed by OSP.	1 Starter Pack 60 28	None _____ _____
☐ Siliq™ ****REMS Required****	☐ 210mg Syringe	☐ Starter dose: Administer 210mg by subcutaneous injection at weeks 0, 1, and 2, followed by 210 mg every 2 weeks. ☐ Maintenance dose: Inject 210mg SQ every 2 weeks	4 week supply	
☐ Skyrizi	☐ 150mg (75 mg x 2) Prefilled Syringes	☐ Inject 2 syringes (150mg) under the skin at weeks 0, 4, and then every 12 weeks thereafter Inject 150mg under the skin every 12 weeks	Loading dose 12 week supply	None
☐ Stelara®	☐ 45mg Prefilled Syringe ☐ 90mg Prefilled Syringe	☐ Inject 45mg on day 0, then week 4, then every 12 weeks, **for patient ≤ 220lbs.** ☐ Inject 90mg on day 0, then week 4, then every 12 weeks, **for patients > 220lbs.**	4 week supply	
☐ Taltz	☐ 80mg autoinjector pen ☐ 80mg prefilled syringe	☐ 160mg subcutaneously once, followed by 80mg subcutaneously at weeks 2, 4, 6, 8, 10, and 12; then 80mg subcutanously every 4 weeks. ☐ 160mg subcutaneously once, followed by 80mg subcutaneoulsy every 4 weeks. ☐ Inject 80mg subcutaneously once every 4 weeks.	Loading Dose 4 week supply	None _____
☐ Tremfya™	☐ 100mg Prefilled Syringe	☐ Inject 100mg subcutaneously at week 0 & week 4, then every 8 weeks thereafter. ☐ Inject 100mg subcutaneously every 8 weeks.	Loading Dose 8 week supply	None
☐ Cosentyx™	☐ 150mg Sensoready Pen ☐ 300mg Sensoready Pen ☐ 150mg Prefilled Syringe ☐ 300mg Prefilled Syringe	☐ Inject dose subcutaneously on week 0, 1, 2, 3, 4. ☐ Inject dose subcutaneously every 4 weeks.	Loading Dose 4 week supply	None _____
☐ Ilumya™	☐ 100mg Prefilled Syringe	☐ Inject dose subcutaneously at weeks 0, 4, 12 weeks thereafter ☐ Inject dose subcutaneously every 12 weeks		
☐ Other:				

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: _____