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



## **GASTROENTEROLOGY**

Order Form

Suspension    Cimzia®   200x2 Prefilled Syringe   Starter Kit: Inject 400mg subcutaneously at weeks 0, 2, and 4   4 week supply   Inject 400mg subcutaneously once every 4 weeks   4 week supply   Inject 400mg subcutaneously once every 4 weeks   4 week supply   Inject 400mg subcutaneously once every 4 weeks   4 week supply   Inject 400mg subcutaneously once every 8 weeks   Inject 160mg on day 1 then week 2 inject 80mg subcutaneously on day 15, then inject 40mg every other week 2 inject 80mg subcutaneously on day 15, then inject 40mg every other week starting on day 29   Week 4+: Inject 40mg subcutaneously every other week   4 week supply   Week 4+: Inject 40mg subcutaneously every other week   4 week supply   Loading Dose   Inject 200mg SubQ at week 0, 100mg at week 2, then 100mg every 4 weeks   Loading Dose   Loading Dose   Inject 100mg every 4 weeks   Inject 100mg subcutaneously once every 4 weeks   Loading Dose   Maintenance: Infuse 90mg SQ 8 weeks after initial infusion and then every 8 weeks   Inject 10mg tablet   Take 10mg by mouth twice daily for 8 weeks (loading dose)   Loading Dose   Week supply   Itablet by mouth twice aday   Week supply   Week supply   Itablet by mouth 3x's a day   Week supply   Week supply   Itablet by mouth 3x's a day   Itablet by mouth 3x's a day				PATIENT INFO	RMATION	demographics atta	ached		
State   Zip   Phone:   INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK   MEDICAL INFORMATION	Patient Nam	ne:				DOB:	Sex: $\square$ M	□ F	
INSURANCE INFORMATION:   PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK	Address:					Patient SSN:			
Wt:	City:          State:          Phone:								
Wt:	INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK								
Diagnosis Date:/	MEDICAL INFORMATION								
Other	Wt: Ht: Allergies:								
Other	Diagnosis Date:/   ICD-10 Code:							Colitis	
NSAIDS   Duration     Sulfasalazine   Duration       G-MP (G-Merceptapurine)   Duration	<del>-</del>								
Biologics   Duration   S-ASA (S-Aminosalicylates)   Duration   Other   Duration   Dura									
Bibliogics   Duration   Azathioprine   Duration   Other   Duration   Other   Duration   Is the patient currently on any therapy?   YES   NO   New med start date:   Other meds patient is top taking meds before starting new med?   YES   NO   New med start date:   Other meds patient is currently taking:   Test Results:   Test Results									
Other meds patient is currently taking:  Test Results:  PRESCRIPTION INFORMATION  New   Refill   Needs by:									
Test Results:    PRESCRIPTION INFORMATION   PRESCRIPTION   PRESCRI	Is the patient currently on any therapy?    YES    NO List meds:								
TEST Results:    PRESCRIPTION INFORMATION   Patient's Home   Doctor's Office   Other:	Will patient stop taking meds before starting new med? ☐ YES ☐ NO New med start date:								
Test Results:	Other meds patient is currently taking:								
New   Refill   Needs by:									
New									
DRUG									
Cimzia®			/			tor's Office ☐ Other:	OLIANITITY (		
Alinia®	DRI	<del></del>	Take 1 tablet (5			food	QUANTITY	REFILLS	
Schritzlas   200x2 LYO Powder   Inject 400mg subcutaneously once every 4 weeks   4 week supply   2	□ Alinia®	□100 mg/5 mL Oral			=				
Humira®	□ Cimzia®						4 week supply		
Humira®     40mg Pen	☐ Entyvio®	□ 300mg vial							
Citrate Free	☐ Humira®	☐ Crohn's Starter Kit					Loading Dose	none	
Simponi® UC	☐ Humira® Citrate Free	=	☐ Week 4+ : Inject 40mg subcutaneously every other week				4 week supply		
Infuse 100mg Prefilled Syringe   Infuse 100mg subcutaneously once every 4 weeks   4 week supply			□ Inject 200mg S	SubQ at week 0, 100	mg at week 2. the	en 100mg every 4 weeks			
Maintenance: Infuse 90mg SQ 8 weeks after initial infusion and then every 8 weeks	□ Simponi® UC						_		
Take   Image to the property of the property	□ Stelara®		☐ Maintenance: I	nfuse 90mg SQ 8 we					
1 tablet by mouth 3x's a day   2 week supply 3 day supply   3 day supply 3 day supply 3 day supply 3 day supply 3 day supply 3 day supply 3 day supply 3 day supply 3 day supply 3 day supply 3 day supply 3 day supply 4 day supply 5 day supply 5 day supply 5 day supply 5 day supply 6 day supply 6 day supply 6 day supply 8 day supply 8 day supply 9 day su	□ Xeljanz		_ ,	•		•	_	None	
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:	□Xifaxan®	=	☐ 1 tablet by mo	uth 3x's a day			2 week supply		
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: Tax ID: NPI: DEA: License: License: Deate:	Other:			· · · · · · · · · · · · · · · · · · ·					
Physician Signature: Date:   Physician Name: DEA:   License: License:			F	PHYSICIAN INFO	RMATION				
Physician Name:	By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as								
NPI: DEA: License:	Physician Signature:					Date:			
NPI: DEA: License:	Physician Name:					Tax ID:			
- · · · · · · · · · · · · · · · · · · ·									
Phone: Fax: Contact Person:									

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