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

PARAGON SPECIALTY

GASTROENTEROLOGY
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

Wt: _____ Ht: _____ Allergies: _____

Diagnosis Date: ____ /____ /_____ ICD-10 Code: _____ ☐ Crohn's Disease ☐ Ulcerative Colitis

☐ Other: _____

History: Has Patient been previously treated for this condition? ☐ YES ☐ NO

☐ NSAIDS	Duration_____	☐ Sulfasalazine	Duration_____	☐ Corticosteroid	Duration_____
☐ MTX	Duration_____	☐ 5-ASA (5-Aminosalicylates)	Duration_____	☐ 6-MP (6-Mercaptapurine)	Duration_____
☐ Biologics	Duration_____	☐ Azathioprine	Duration_____	☐ Other	Duration_____

Is the patient currently on any therapy? ☐ YES ☐ NO List meds: _____

Will patient stop taking meds before starting new med? ☐ YES ☐ NO New med start date: _____

Other meds patient is currently taking: _____

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

Test Results: _____

PRESCRIPTION INFORMATION

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

DRUG		DIRECTIONS	QUANTITY	REFILLS
☐ Alinia®	☐ 500 mg Tablets ☐ 100 mg/5 mL Oral Suspension	☐ Take 1 tablet (500 mg) by mouth every 12 hours with food. ☐ Take _____mL by mouth every 12 hours with food.		
☐ Cimzia®	☐ 200x2 Prefilled Syringe ☐ 200x2 LYO Powder	☐ Starter Kit: Inject 400mg subcutaneously at weeks 0, 2, and 4 ☐ Inject 400mg subcutaneously once every 4 weeks	4 week supply	
☐ Entyvio®	☐ 300mg vial	☐ Loading Dose: Infuse 300mg IV over 30 minutes at weeks 0, 2, and 6 ☐ Maintenance: Infuse 300mg IV over 30 minutes every 8 weeks		
☐ Humira® ☐ Humira® Citrate Free	☐ Crohn's Starter Kit ☐ 40mg Pen ☐ 40mg Prefilled Syringe	☐ Inject 160mg on day 1 then 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 _____	Loading Dose 4 week supply	none _____
☐ Simponi® UC	☐ 100mg SmartJect ☐ 100mg Prefilled Syringe	☐ Inject 200mg SubQ at week 0, 100mg at week 2, then 100mg every 4 weeks ☐ Infuse 100mg subcutaneously once every 4 weeks	Loading Dose 4 week supply	
☐ Stelara®		☐ Initial Infusion: Infuse _____mg IV over 1 hour x 1 dose ☐ Maintenance: Infuse 90mg SQ 8 weeks after initial infusion and then every 8 weeks		
☐ Xeljanz	☐ 5mg tablet ☐ 10mg tablet	☐ Take 10mg by mouth twice daily for 8 weeks (loading dose) ☐ Take ____mg by mouth twice daily as maintenance dose	Loading Dose 4 week supply	None _____
☐ Xifaxan®	☐ 550mg Tablets ☐ 200mg Tablets	☐ 1 tablet by mouth twice a day ☐ 1 tablet by mouth 3x's a day ☐ 1 tablet by mouth 3x's a day	4 week supply 2 week supply 3 day supply	
☐ 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: _____