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

PARAGON SPECIALTY

HEPATOLOGY
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

Weight: _____ Height: _____ Allergies: _____

Diagnosis Date: ____/____/_____ ICD-10 Code: _____ ☐ Chronic Hepatitis ☐ Hepatic Encephalopathy

☐ Hepatocellular Carcinoma ☐ Other: _____

Genotype: ☐ 1 ☐ 1a (Q80K Polymorphism: ☐ Yes ☐ No) ☐ 1b ☐ 2 ☐ 2a ☐ 2b ☐ 3 ☐ 3a ☐ 3b ☐ 4 ☐ 4a ☐ 4b ☐ 6

Viral Load: _____ IU/ml Viral Load Date: _____

☐ Treatment Naive ☐ Previously Treated: Prior treatment used: _____

☐ Non-Responder ☐ Responder/Relapser Duration of previous therapy: _____ to _____ Total of: _____months

HIV Coinfected: ☐ Yes ☐ No HBV Coinfected: ☐ Yes ☐ No Compensated Liver Disease: ☐ Yes ☐ No

Cirrhosis: ☐ Yes ☐ No Metavir Score: _____ Solid Organ Transplant recipient: ☐ Yes ☐ No Awaiting Liver Transplant: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

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

DRUG	DIRECTIONS				QUANTITY	REFILLS
☐ Epclusa®	☐ Take 1 tablet by mouth daily with or without food				28 day supply	
☐ Harvoni® 90mg/400mg Tablet	☐ Take 1 tablet by mouth daily with or without food				28 day supply	
☐ Moderiba 200mg Tablet ☐ Ribavirin 200mg Tablet ☐ Ribavirin 200mg Capsule	☐ 600mg AM and 600mg PM (1200mg) ☐ 400mg AM and 400mg PM (800mg) ☐ Other: Take _____mg AM and _____mg PM			☐ 600mg AM and 400mg PM (1000mg) ☐ 400mg AM and 200mg PM (600mg)	28 day supply	
☐ Riba-Pak® *(ribavirin)* ☐ Moderiba Pak® *(ribavirin)*	☐ 600mg AM and 600mg PM (1200mg) ☐ 400mg AM and 400mg PM (800mg)			☐ 600mg AM and 400mg PM (1000mg) ☐ 400mg AM and 200mg PM (600mg)	28 day supply	
☐ Mavyret 100mg/40mg Tablet	☐ Take 3 tablets by mouth daily with food				28 day supply	
☐ Peg-Intron® Redipen	Less than 88lbs	Less than 40kg	50mcg/0.5ml	50mcg (0.5ml) SubQ weekly	28 day supply	
	89 - 111 112 - 133	40 – 50 51 – 60	80mcg/0.5ml	64mcg (0.4ml) SubQ weekly 80mcg (0.5ml) SubQ weekly		
	134 – 166 167 - 187	61 – 75 76 - 85	120mcg/0.5ml	96mcg (0.4ml) SubQ weekly 120mcg (0.5ml) SubQ weekly		
	greater than 187	greater than 85	150mcg/0.5ml	150mcg (0.5ml) SubQ weekly		
☐ Procrit ☐ Neupogen SingleJect	Inject: ☐ 40,000 units SubQ every week ☐ Other: _____ Inject: ☐ 300mcg ☐ 480mcg SubQ ☐ weekly ☐ twice weekly ☐ three times weekly				28 day supply	
☐ Vosevi 400mg/100mg Tablet	☐ Take 1 tablet by mouth daily with food				28 day supply	
☐ Xifaxan 550mg Tablet	☐ Take 1 tablet by mouth twice daily **indicate previously failed therapy (Lactulose) _____				30 day supply	
☐ Zepatier™	☐ Take 1 tablet by mouth once per day with or without food				28 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: _____