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

PARAGON SPECIALTY

RHEUMATOLOGY
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: _____

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

Diagnosis Date: ____ /____ /_____ ICD-10 Code: _____ ☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis

☐ Crohn's Disease ☐ Systemic Lupus Erythematosus ☐ Mod to Sev Plaque Psoriasis

☐ Osteoporosis ☐ Other: _____

Tried & Failed Medications:

☐ Methotrexate Duration: _____ Reason for Discontinuing: _____

☐ _____ Duration: _____ Reason for Discontinuing: _____

☐ _____ Duration: _____ Reason for Discontinuing: _____

Forteo/Prolia: T-Score _____ Type _____ Date _____

Fracture History: Site _____ Date _____ Site _____ Date _____

PRESCRIPTION INFORMATION

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

DRUG		DIRECTIONS	QUANTITY	REFILLS
☐ Actemra®	☐ 162mg Prefilled Syringe ☐ _____	☐ Inject 162mg subcutaneously ☐ ONCE a week or ☐ every OTHER week ☐ Infuse _____mg at _____	4 week supply	
☐ Cimzia®	☐ 200x2 Prefilled Syringe ☐ 200x2 LYO Powder	☐ Initial: Inject 400mg subcutaneously at weeks 0, 2, and 4 ☐ Maintenance: Inject 400mg subcutaneously once every 4 weeks ***OR*** ☐ Inject 200mg subcutaneously once every 2 weeks	4 week supply	
☐ Cosentyx™	☐ 150mg Sensoready Pen ☐ 300mg Sensoready Pen ☐ 150mg Pre-filled Syringe ☐ 300mg Pre-filled Syringe	☐ Inject dose subcutaneously on week 0, 1, 2, 3, 4 ☐ Inject dose subcutaneously every 4 weeks	Loading Dose 4 week supply	none _____
☐ Enbrel®	☐ 50mg Sureclick ☐ 50mg Prefilled Syringe ☐ 25mg PFS or ☐ Vials	☐ Inject 50mg subcutaneously ONCE a week ☐ Inject 25mg subcutaneously TWICE a week 72 – 96 hours apart	4 week supply	
☐ Humira® ☐ Humira® Citrate-Free	☐ 40mg Pen ☐ 40mg Prefilled Syringe	☐ Inject 40mg subcutaneously EVERY OTHER week ☐ Inject 40mg subcutaneously ONCE a week	4 week supply	
☐ Otezla®	☐ Starter Pack ☐ 30mg Tablets	☐ Titration: Take 1 tablet on day 1 then twice daily as directed ☐ Take 1 tablet by mouth twice daily	1 Starter Pack 60	none _____
☐ Olumiant	☐ 2mg tablet	☐ Take 1 tablet (2mg) once daily with or without food	4 week supply	_____
☐ Prolia®	☐ 60mg Syringe	☐ Inject 60mg subcutaneously once every 6 months	4 week supply	
☐ Simponi ARIA®	☐ 50mg SmartJect ☐ _____	☐ Inject 50mg subcutaneously ONCE a MONTH as directed ☐ Infuse _____mg at weeks 0 and 4, then every 8 weeks thereafter	4 week supply	
☐ Stelara®	☐ 45mg Prefilled Syringe	☐ Inject 45mg on day 0, then week 4, then every 12 weeks	4 week supply	
☐ Xeljanz® ☐ Xeljanz® XR	☐ 5mg Tablets ☐ 11mg Tablets	☐ Xeljanz 1 tab by mouth twice daily as directed ☐ Xeljanz XR 1 tab by mouth daily as directed	60 30	
☐ 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: _____