

PATIENT INFORMATION

Demographics Attached

Patient Name: _____ DOB: _____ Phone: _____

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

MEDICAL INFORMATION

Patient Weight: _____ lbs. Allergies: _____
 Diagnosis Date: _____ ICD-10: _____ ** Date of last: Orencia, Remicade, Humira, Enbrel, _____ Dose: _____
 Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached
Labs: Required labs to be drawn by: Infusion Clinic Referring Physician
Lab Orders: _____
Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required. (Cimzia, Remicade, Rituxan and Simponi Aria)
Hep B Labs: Hep B antigen attached Hep B Core antibody total attached Draw Hep B Labs
TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. (Cimzia, Remicade, Stelara, and Ilumya)
TB Test: TB Test Attached Perform TB Testing

INJECTION AND INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
<input type="checkbox"/> Cellulitis <input type="checkbox"/> MRSA <input type="checkbox"/> Skin Infection / Abscess	<input type="checkbox"/> Cubicin <input type="checkbox"/> 4mg/kg IV <input type="checkbox"/> 6mg/kg IV <input type="checkbox"/> Baseline CPK and BMP <input type="checkbox"/> Daily for _____ days _____ weeks <input type="checkbox"/> Dalvance <input type="checkbox"/> 1000mg IV followed one week later by 500mg <input type="checkbox"/> 750mg IV followed one week later by 375mg (CrCl<30) <input type="checkbox"/> 1500mg IV x 1 dose <input type="checkbox"/> 1125mg IV x 1 dose (CrCl<30) <input type="checkbox"/> Orbactiv 1200mg IV <input type="checkbox"/> Rocephin <input type="checkbox"/> 1gm IV <input type="checkbox"/> 2gm IV <input type="checkbox"/> Daily for _____ days _____ weeks	
<input type="checkbox"/> Hypogammaglobulinemia <input type="checkbox"/> Common Variable Immunodeficiency (CVID)	<input type="checkbox"/> IVIG Orders: _____ gm/kg IV divided over _____ day(s) _____ mg/kg IV divided over _____ day(s) Frequency: Every _____ weeks for one year OR _____ one time dose Protocol Pre-Medication Orders: <input type="checkbox"/> Tylenol 1000mg PO Antihistamine: <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO Additional Pre-Medication Orders: <input type="checkbox"/> Solu-Medrol _____ mg IV <input type="checkbox"/> NS 0.9% _____ mL IV	
<input type="checkbox"/> Chronic Idiopathic Urticaria	<input type="checkbox"/> Xolair <input type="checkbox"/> 150mg SQ every 4 weeks <input type="checkbox"/> 300mg SQ every 4 weeks ** Date of last injection: _____ Note: Patient must have an EpiPen in their possession on their appointment date	
<input type="checkbox"/> Pemphigus Vulgaris	<input type="checkbox"/> Rituxan Initial Dose: <input type="checkbox"/> 1000mg IV at 0, 15 days Maintenance: <input type="checkbox"/> 500mg IV at month 12 and every 6 months thereafter Pre-Medication Orders: <input type="checkbox"/> Tylenol 1000mg PO and Benedryl 50mg PO/IV <input type="checkbox"/> Solu-Medrol 100mg IV <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prednisone Rx from referring provider	
<input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Plaque Psoriasis	<input type="checkbox"/> Remicade _____ mg/kg IV every _____ weeks <input type="checkbox"/> Remicade _____ mg/kg IV on weeks 0, 2, 6, and then every 8 weeks Pre-Medication Orders: <input type="checkbox"/> Tylenol 1000mg Antihistamine: <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO Additional Pre-Medication Orders: <input type="checkbox"/> Solu-Medrol 62.5mg IV <input type="checkbox"/> Solu-Medrol 125mg IV <input type="checkbox"/> Solu-Cortef _____ mg IV <input type="checkbox"/> SimponiARIA Initial Dose: <input type="checkbox"/> 2mg/kg IV at weeks 0, 4, and then every 8 weeks Maintenance: <input type="checkbox"/> 2mg/kg IV every 8 weeks <input type="checkbox"/> Solu-Medrol 1gm IV daily x <input type="checkbox"/> 3 days <input type="checkbox"/> _____ days <input type="checkbox"/> Stelara <input type="checkbox"/> Patients weighing <100kg (220lbs), 45mg SQ initially and 4 weeks later followed by 45mg every 12 weeks <input type="checkbox"/> Patients weighing >100kg (200lbs), 90mg SQ initially and 4 weeks later followed by 90mg every 12 weeks <input type="checkbox"/> Ilumya Initial Dosing: <input type="checkbox"/> 100mg SQ at weeks 0, 4, and every 12 weeks thereafter Maintenance: <input type="checkbox"/> 100mg SQ every 12 weeks <input type="checkbox"/> Cimzia <input type="checkbox"/> Initial Dose: 400mg SQ at weeks 0, 2, and 4 <input type="checkbox"/> Maintenance: <input type="checkbox"/> 200mg SQ every 2 weeks OR <input type="checkbox"/> 400mg SQ every 4 weeks <input type="checkbox"/> Other _____ mg every 4 weeks	

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 and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Arlington Austin Dallas Houston Knoxville North Hills Plano Round Rock San Antonio Stone Oak
 P: 817.200.2530 P: 512.261.4800 P: 877.365.5566 P: 877.365.5566 P: 877.365.5566 P: 817.284.2700 P: 469.974.0565 P: 877.365.5566 P: 210.366.4358 P: 210.485.3700
 F: 817.509.0011 F: 512.261.4803 F: 855.889.2946 F: 855.889.2946 F: 855.889.2946 F: 817.284.2701 F: 469.608.2072 F: 855.889.2946 F: 210.366.4896 F: 210.390.1738

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