PARAGON
INFUSION CENTERS

GASTROENTEROLOGY ORDER FORM

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)
Hep B Labs: ☐ Hep B antigen attached ☐ Hep B Core antibody total attached ☐ Draw Hep B Labs (Cimzia)

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. (Cimzia, Remicade, Stelara, and Entyvio)
TB test: ☐ TB Test Attached ☐ Perform TB testing

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐ Dehydration ☐ Gastroenteritis ☐ Diverticulitis	☐ 1 Liter/ ☐ 2 Liters D5 .45% NS IV x 1 day ☐ 1 Liter/ ☐ 2 Liters NS IV x 1 day ☐ **Cipro** 400mg IV daily x 1 day ☐ **Flagyl** 500mg IV daily x 5 days ☐ **Invanz** 1gm IV daily x 1 day	☐ ________ ☐ x 1 year
☐ Iron Deficiency Anemia ☐ Iron Deficiency Anemia with CKD not on dialysis **Required Recent Labs: HGB, HCT, TIBC, Ferritin**	☐ **Venofer** 200mg IV q 3 weeks x 5 doses ☐ **Venofer** 100 mg IV q week x 7 weeks then every other week x 7 weeks ☐ **Venofer** 200mg IV - Administer 5 doses over a 14 day period ☐ **Venofer** 200mg IV weekly x 5 weeks ☐ **Injectafer** 15mg/kg IV - Give 2 doses at least 7 days apart not to exceed 1500mg *if patient weighing less than 50kg (110lbs)* ☐ **Injectafer** 750mg IV - Give 2 doses at least 7 days apart not to exceed 1500mg *if patient weighing 50kg (110lbs) or greater*	☐ ________ ☐ x 1 year
☐ Crohn's Disease ☐ Ulcerative Colitis	☐ **Cimzia** 400mg Sub-Q at weeks 0, 2, 4 and then every 4 weeks ☐ **Cimzia** ________mg Sub-Q every ________ weeks ☐ **Remicade** ________mg/kg ☐ every ________ weeks ☐ **Remicade** ________mg/kg on weeks 0, 2, 6 and then every 8 weeks Pre-medication Orders: ☐ Tylenol 1000mg Antihistamine: ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO Additional Pre-Medication Orders: ☐ Solu-Medrol 62.5mg IVP ☐ Solu-Medrol 125mg IVP ☐ Solu-Cortef ________mg IVP ☐ **Stelara** initial infusion: ☐ <55kg 260mg IV over 1 hour x 1 dose ☐ 55kg to 85kg 390mg IV over 1 hour x 1 dose ☐ >85kg 520 mg IV over 1 hour x 1 dose ☐ **Stelara** maintenance: ☐ 90mg SQ 8 weeks after initial and then every 8 weeks. ☐ **Tysabri** 300mg every 4 weeks ☐ JCV antibody ☐ Patient TOUCH authorization ☐ **Entyvio** 300mg IV over 30 minutes at 0, 2, 6 weeks and then Q8weeks (baseline LFTs) ☐ **Entyvio** 300mg IV every 8 weeks	☐ ________ ☐ x 1 year

PHYSICIAN INFORMATIONPHYSICIAN 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 LOCATION

☐ Arlington	☐ Austin	☐ Dallas	☐ Houston	☐ Knoxville	☐ North Hills	☐ Plano	☐ Round Rock	☐ San Antonio	☐ Stone Oak
P: 817.200.2530	P: 512.261.4800	P: 972.408.2777	P: 713.860.1755	P: 865-299-7525	P: 817.284.2700	P: 469-974-0565	P: 737-443-5230	P: 210.366.4358	P: 210.485.3700
F: 817.509.0011	F: 512.261.4803	F: 469.913.6894	F: 713.277.7219	F: 865-338-5604	F: 817.284.2701	F: 469-608-2072	F: 737-402-7698	F: 210.366.4896	F: 210.390.1738

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