

## 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: \_\_\_\_\_

- Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached       Last MRI documentation attached  
 Patient's TOUCH authorization (only for Tysabri orders)       Hepatitis B antigen and Hepatitis B Core total antibody required (only for Ocrevus orders)

Labs: Required labs to be drawn by:  Infusion Clinic     Referring Physician

Lab Orders: \_\_\_\_\_

## INFUSION ORDERS

### Pre-Medication:

- Zofran 4mg slow IVP     Zofran 8mg IVP     Pepcid IV 20mg IVP     Toradol 30mg IVP  
 Solu-Medrol 125mg IVP     Reglan 10mg IV/100mL NS over 20 minutes

Migraines  
ICD-10: \_\_\_\_\_

### Protocol:

- Depacon     500mg     750mg in 250mL NS  
 Magnesium Sulfate 1gm IV in 250mL  
 DHE 45     0.5mg     1mg IV in 100mL NS (must premed for nausea)  
 File this as a standing order for \_\_\_\_\_ months.

Multiple Sclerosis  
Exacerbation  
ICD-10: \_\_\_\_\_

- Solu-Medrol 1gm IV daily x \_\_\_\_\_ days  
 Solu-Cortef 1gm IV daily x \_\_\_\_\_ days

Multiple Sclerosis  
ICD-10: \_\_\_\_\_

- Tysabri 300mg IV every 4 weeks (after registering patient with TOUCH)  
 Pre-medication protocol: Tylenol 1000mg PO and Benadryl 25mg PO  
 Date of last interferon dose \_\_\_\_\_  
 Ocrevus  300mg IV at 0 and 2 weeks, then 600 mg IV every 6 months  
 600 mg IV every 6 months  
 Pre-Medication Protocol: Solu-Medrol 100mg IV and Benadryl 25mg PO to be given 30 minutes before infusion  
 Date of last interferon dose \_\_\_\_\_

## IVIG ORDERS

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_ IVIG Brand \_\_\_\_\_

IVIG Orders: \_\_\_\_\_ mg/kg OR \_\_\_\_\_ gm/kg IV divided over \_\_\_\_\_ day(s)

Frequency: Every \_\_\_\_\_ weeks or \_\_\_\_\_ one time dose

Protocol Pre-Medication Orders: Tylenol 1000mg PO

please choose one antihistamine:  Cetirizine 10mg PO     Diphenhydramine 25mg PO     Loratadine 10mg PO

Additional Pre-Medication Orders:  Solu-Medrol \_\_\_\_\_ mg IVP

## 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 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