PARAGON
INFUSION CENTERS

OB/GYN
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: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

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

Lab Orders: _____

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐ Hyperemesis _____	☐ 1 Liter/ ☐ 2 Liters D5 .45% NS IV x 1 day ☐ 1 Liter/ ☐ 2 Liters NS IV x 1 day ☐ Zofran 4mg IV ☐ 1 Liter/ ☐ 2 Liters Ringers Lactate IV x 1 Day ☐ Zofran 8mg IV ☐ 1 Liter/ ☐ 2 Liters D5/Ringers Lactate x 1 Day	☐ _____ ☐ x 1 year
Primary ICD-10 ☐ Iron Deficiency Anemia _____ ☐ Iron Deficiency Anemia with CKD not on dialysis _____ ☐ Other medical necessity: _____ **Required Recent Labs: HGB, HCT, TIBC, Ferritin**	**Last Iron dose** (if applicable) _____ **Secondary ICD-10 **Medicare Required**** ☐ Adverse Effect of other drug _____ *(Oral iron intolerance or not adequate)* ☐ Other medical necessity:_____ ☐ **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 (10 doses total) ☐ **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
☐ Pyelonephritis _____ ☐ Complicated UTI _____ **Required Labs: CBC, BMP**	☐ Rocephin 1gm IV daily x 7 days ☐ Rocephin 2gms IV daily x 7 days ☐ Invanz 1gm IV daily x 7 days	☐ _____ ☐ x 1 year
☐ Migraines _____ **Required Labs: LFTs if ordering Depacon treatment**	☐ Zofran 4mg IV ☐ Magnesium Sulfate 1gm IV ☐ Zofran 8mg IV ☐ Depacon 500mg IV ☐ Reglan 10mg IV ☐ DHE 45 1mg IV	☐ _____ ☐ 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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