



# PULMONARY 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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Pneumonia (486)            | <input type="checkbox"/> Zithromax 500mg IV daily x 3 days                       | <input type="checkbox"/> Invanz 1gm IV daily x 7 days |
| <input type="checkbox"/> Chronic Bronchitis (491.8) | <input type="checkbox"/> Zithromax 500mg IV daily x 3 days                       |   |
| <input type="checkbox"/> _____                      | <input type="checkbox"/> Solu-Medrol 125mg IVP x 1 day, then 62.5mg IVP x 3 days |   |
| <input type="checkbox"/> _____                      | <input type="checkbox"/> _____   |   |

## XOLAIR INJECTION

Allergic Asthma (ICD-10: \_\_\_\_\_)  \_\_\_\_\_

Xolair Dose:  150mg  225mg  300mg  375mg      Frequency: Subcutaneously every  2 weeks or  4 weeks

History: Positive Skin or RAST Test:  Yes  No      Test date: \_\_\_\_\_

Pre-Treatment IgEx Serum: \_\_\_\_\_ IU/ml      Test date: \_\_\_\_\_

\*\* Date of last Xolair Injection: \_\_\_\_\_      Note: Patient must have an EpiPen in their possession with every appointment.

## PROLASTIN INFUSION

Alpha-1 Antitrypsin Deficiency ( \_\_\_\_\_ ) Panacinar Emphysema ( \_\_\_\_\_ )

Prolastin Dose:  60mg/kg IV weekly **OR**  Other: \_\_\_\_\_

Premedication: \_\_\_\_\_

Rate:  As tolerated by patient up to 0.08mL/kg/min       Other: \_\_\_\_\_

\*\* Date of last Prolastin Infusion: \_\_\_\_\_

## ADDITIONAL ORDERS/COMMENTS

## 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

- |                                    |                                 |                                 |                                  |                                    |                                      |                                |                                     |                                      |                                    |
|------------------------------------|---------------------------------|---------------------------------|----------------------------------|------------------------------------|--------------------------------------|--------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Arlington | <input type="checkbox"/> Austin | <input type="checkbox"/> Dallas | <input type="checkbox"/> Houston | <input type="checkbox"/> Knoxville | <input type="checkbox"/> North Hills | <input type="checkbox"/> Plano | <input type="checkbox"/> Round Rock | <input type="checkbox"/> San Antonio | <input type="checkbox"/> 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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