PARAGON
INFUSION CENTERS

ALLERGY & IMMUNOLOGY
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:_____

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

History of Allergic Asthma (Xolair): Positive Skin or RAST Test ☐ Yes ☐ No Test Date:_____

Pre-Treatment IgE Serum: _____ IU/ml Test Date: _____ ** Date of last☐ Xolair dose:_____

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

Required Labs: ☐ CBC with differential (Cinqair, Fasenra, and Nucala) ☐ BMP or Cr (IVIG)

Lab Orders: _____

***Note**: Patient must have their EpiPen in their possession at every Xolair appointment

INFUSION ORDERS

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐ Allergic Asthma ICD-10 _____ ☐ Chronic Idiopathic Urticaria ICD-10 _____	☐ **Xolair** 150mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for _____ months ☐ **Xolair** 225mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for _____ months ☐ **Xolair** 300mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for _____ months ☐ **Xolair** 375mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for _____ months	☐ _____ ☐ x 1 year
☐ Severe Allergic Asthma with Eosinophilic phenotype ICD-10 _____ ☐ Eosinophilic Granulomatosis With Polyangiitis ICD-10 _____	☐ **Cinqair** 3mg/kg IV every 4 weeks for _____ months ☐ **Fasenra** initial dose: 30mg Sub-Q every 4 weeks for the first 3 doses followed by 30 mg Sub-Q every 8 weeks thereafter for ____ months ☐ **Fasenra** maintenance dose: 30mg Sub-Q every 8 weeks for____ months ☐ **Nucala** 100mg Sub-Q every 4 weeks for ____ months ☐ **Nucala** 300mg Sub-Q every 4 weeks for ____ months	☐ _____ ☐ x 1 year
☐ Common Variable Immunodeficiency ICD-10 _____ ☐ Other: _____ ICD-10 _____	IVIG Brand: ☐ Bivigam ☐ Carimune ____ % ☐ CytoGam ☐ Flebogamma 5% ☐ Flebogamma 10% ☐ Gammagard ☐ Gammaked ☐ Gammaplex ☐ Gamunex C ☐ Octagam ☐ Privigen IVIG Pre-medication Orders: ☐ Tylenol 1000mg Antihistamine: ☐ Cetrizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO Additional Pre-Medication Orders: ☐ Solu-Medrol ___mg IVP ☐ NS 0.9% ____ mL IV ☐ **IVIG** Order: _____ mg /kg IV over _____ day(s) ☐ **IVIG** Order: _____ gm/kg IV over _____ day(s) Frequency: ☐ Every _____ weeks for ____ months or ☐ One-time dose ONLY	☐ _____ ☐ x 1 year

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

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