

<b>PAPZIMEOS® (ZOPAPOGENE IMADENOVEC-DRAB) PRESCRIBER ORDER FORM</b>					
Patient Name:			Date of Birth:		Gender:
Address:					
Phone:		Height:	<input type="checkbox"/> Inches <input type="checkbox"/> cm		Weight:
<b>Clinical Information</b>					
Primary Diagnosis Description:				ICD-10 Code:	
Allergies: <input type="checkbox"/> NKDA OR (List):					
<b>Papzimeos (zopapogene imadenovec-drab) Medication Order</b>					
<p><b>RX: Papzimeos 5 x 10<sup>11</sup> particle units (PU) per injection (4 doses)</b></p> <p>Administer the recommended dosage of 5 x 10<sup>11</sup> particle units (PU) via subcutaneous injection 4 times over a 12-week interval.</p> <p>Initial dose, then 2, 6 and 12 weeks after the initial dose.</p> <p>Initial dose should be administered within 72 hours of debulking procedure and dose 2 within 11-14 days after first dose.</p> <p><input type="checkbox"/> Dispense #4 vials</p> <p><input type="checkbox"/> No refills</p> <p><input type="checkbox"/> Other</p>					
<b>Ancillary Orders</b>					
<p><b>Anaphylaxis Kit</b></p> <p>If this is a 1<sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> dose?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li>▪ Epinephrine 0.3 mg (&gt; 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (&lt; 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.</li> <li>▪ Diphenhydramine 25 mg (&gt; 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.</li> <li>▪ 0.9% Sodium Chloride 500 mL (&gt; 30 kg) or 250mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.</li> <li>▪ Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.</li> </ul>					
<p><b>Lab Orders</b></p> <p><input type="checkbox"/> No labs ordered at this time.</p> <p><input type="checkbox"/> Other: _____</p>					
<p>Skilled nurse to assess and administer as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.</p> <p>If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy and skilled nursing plan of treatment will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.</p>					
<p><i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i></p>					
Prescriber Signature: _____				Date: _____	
<b>Prescriber Information</b>					
Prescriber Name:			Phone:		Fax:
Address:			NPI:		
City, State:		Zip:		Office Contact:	
<b>Fax completed form, insurance information, and clinical documentation to: (713) 983-4647</b>					
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**Not valid for use for patients residing in Arizona, New York, and Wisconsin.**