PAPZIMEOS® (ZOPAPOGENE IMADENOVEC-DRAB) PRESCRIBER ORDER FORM

Patient Name:		**Date of Birth:**		**Gender:**
Address:				
Phone:	**Height:**	☐ Inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Allergies: ☐ NKDA OR (List):

Papzimeos (zopapogene imadenovec-drab) Medication Order

RX: Papzimeos 5 x 10^{11} particle units (PU) per injection (4 doses)

Administer the recommended dosage of 5 x 10^{11} particle units (PU) via subcutaneous injection 4 times over a 12-week interval.

Initial dose, then 2, 6 and 12 weeks after the initial dose.

Initial dose should be administered within 72 hours of debulking procedure and dose 2 within 11-14 days after first dose.

☐ Dispense #4 vials

☐ No refills

☐ Other

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.
- Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

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.

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.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	

City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to: (713) 983-4647

Not valid for use for patients residing in Arizona, New York, and Wisconsin.

