Local Infusion

MYLOCALINFUSION.COM

PAPZIMEOS (ZOPAPOGENE IMADENOVEC-DRBA) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

DIAGNOSIS (Provider must specify)

❑ Adults with Recurrent Respiratory Papillomatosis: Benign neoplasm of larynx, ICD 10: D14.1

❑ Adults with Recurrent Respiratory Papillomatosis, ICD 10: _____

❑ Other:_____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO ❑ Famotidine 20 mg IV ❑ Cetirizine (Zyrtec) 10 mg PO

❑ Benadryl 25mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Papzimeos	**Dose 1:** Day 1 **Dose 2:** Week 2 **Dose 3:** Week 6 **Dose 4:** Week 12	Subq Injection

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS