Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830

ThrIVewell™
INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

PAPZIMEOS Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Recurrent Respiratory Papillomatosis (RRP)

☐ _____ _____
(other)

PRE-MEDICATION

☐ None required per prescribing guidelines

☐ Other (if clinically indicated): _____

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE:

☐ Dose: 5×10^{11} particle units (PU) per injection

☐ **Frequency: (12-Week Course)**
Dose 1: Day 1 (Initial)
Dose 2: Week 2 (≥11 days after initial)
Dose 3: Week 6
Dose 4: Week 12

Route: Subcutaneous (SQ) injection only

Total dosages_____/ Refills

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____