

Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101



PAPZIMEOS

 Infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> 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 _____