

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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 _____