Provenge Infusion Order

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: ◯ C61 Malignant Neoplasm of Prostate

ICD-10-CM : _____

note, must have C61 and 1 of the 22 ICD-10-CM codes

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

PROVENGE ORDER

Provenge Dose: ☐ Infuse 50 million autologous CD54+ cells activated with PAP-GM-CSF (1 PROVENGE Infusion Bag) over 60 minutes

Frequency: ☐ Administer 3 doses at two week intervals

☐ Administer Q1 weekly - patient with central line

Premeds: ◯ Famotidine 20mg IV ◯ Tylenol 500mg ◯ Ketorlac 30mg

Diphenhydramine ◯ 25mgIV ◯ 50mgIV ◯ Or PO

Methlprednisolone ◯ 40mg ◯ 100mg ◯ 125mg

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____

APHERESIS ORDER FORM FOR PROVENGE®
(sipuleucel-T)

Please complete this form and submit it to the apheresis center designated by *Dendreon On Call*. The location and fax number for the center will be provided to you by *Dendreon On Call*, who can be reached at 877-336-3736.

Prescribing Physician Information

PHYSICIAN NAME:_____

PRACTICE/FACILITY NAME:_____ DATE:_____

Address:_____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ Fax : (_____) _____

Patient Information

PATIENT FIRST NAME:_____ LAST NAME:_____

Date of birth:_____

Order Information

☐ Please check this box to request the following Medication/Protocol: PROVENGE; apheresis collection of mononuclear (MNC) cells per this protocol, three cycles (or additional cycles if deemed necessary), until completion of a full course of PROVENGE therapy (3 complete doses).

Prescribing Physician Authorization

SIGNATURE:_____ DATE:_____

PRINTED NAME:_____

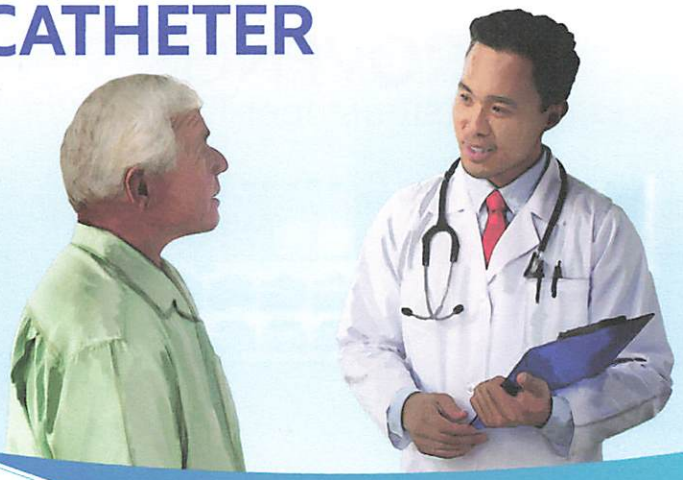
Dendreon

SCAN TO VISIT WEBSITE

PROVENGE.COM/HCP

APHERESIS/DIALYSIS CATHETER ORDER FORM FOR PROVENGE®

(sipuleucel-T)



During the PROVENGE® treatment process, 3 cell collection procedures, known as leukapheresis, will occur approximately 2 weeks apart. A central venous catheter (CVC) may be necessary to collect the cells for certain patients to complete their treatment with PROVENGE.

To order a CVC catheter for treatment with PROVENGE®, complete the following information:
NOTE: Reference the Catheter Care Guide for a list of required supplies.

Prescribing physician information

PHYSICIAN NAME: _____

PRACTICE/FACILITY NAME: _____

Address: _____

City: _____ State: ___ Zip code: _____

Phone: (_____) _____ Fax: (_____) _____

Patient information

FIRST NAME: _____ LAST NAME: _____

Please complete with first and last name as it appears on patient photo ID. Middle initial not required.

Date of birth: _____ Primary phone: (_____) _____

Insurance provider: _____ ID #: _____

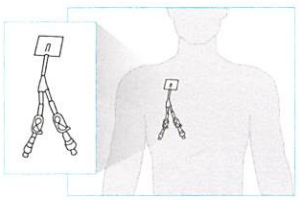
Diagnosis (ICD-10): _____

Order information

DO NOT USE:

The ONLY APPROVED CVC LINE specified for the leukapheresis procedure is:

- **A tunnel apheresis/dialysis catheter, dual lumen, large bore (11.5-14.5 Fr)**
  - For leukapheresis collection of mononuclear cells, with a minimum flow rate of 50 mL/min
- To decrease the risk of occlusion follow guidelines for heparin (5000 units/mL)
- For claim submission, use CPT Code 36558 - placement of a tunneled apheresis catheter



PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME (PRINT): _____

Please see Important Safety Information on the back cover and accompanying full Prescribing Information.