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 25mg   Methlprednisolone 40mgIV 100mIVg 125mgIV

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:____________________________________

SCAN TO VISIT WEBSITE

PROVENGE.COM/HCP

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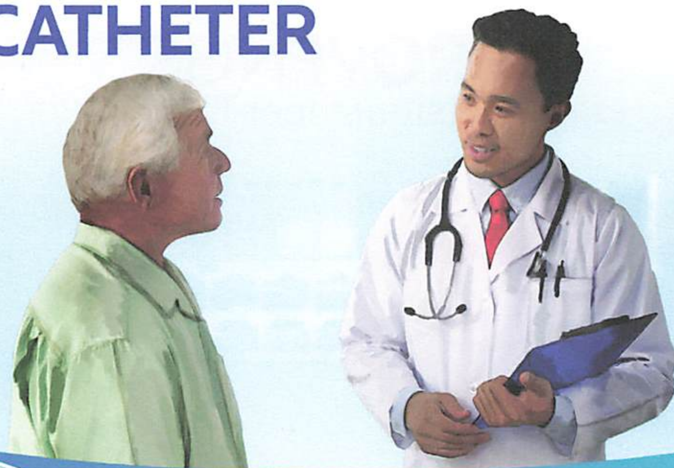
APHERESIS/DIALYSIS CATHETER ORDER FORM FOR PROVENGE®
(sipuleucel-T)



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 #: ______________

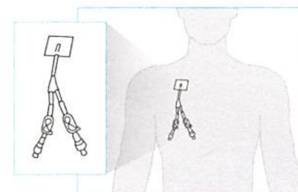
Diagnosis (ICD-10): ______________________________

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.