



PATIENT INFORMATION

Patient Name: _____
 Address: _____
 Servicing Address: _____
 Phone Number: _____ Date of Birth: (MM/DD/YYYY) _____
 E-Mail: _____ Gender: Male Female Unspecified
 Preferred Method of Communication: Call Text Email

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 Primary Contact: _____ NPI: _____
 Contact Phone: _____ Tax ID: _____
 Contact Email: _____ MCD #: _____
 ICD-10 Diagnosis: _____

FACILITY INFORMATION

Facility Name: _____ Primary Contact Name: _____
 Contact Email: _____ Contact Phone: _____
 Address: _____
 White Bag Delivery Address (in-facility infusions only): _____
 NPI #: _____ Tax ID #: _____ MCD #: _____

TREATMENT REGIMEN Expected Cisplatin Start of Care Date

Sample Dose Calculation: Actual Patient Body Weight: 24.9 kg Body Surface Area (BSA): 1.09 m² PEDMARK Dose: 20 g/m²
Dose based on the patient's body weight; see chart below.
Calculation: Multiply the patient's BSA by the PEDMARK Dose: **1.09 m² x 20 g/m² = 21.8 g total PEDMARK to be administered.**

<p>PEDMARK DOSE</p> <p>Weight: _____ kg Height: _____ cm BSA: _____ m²</p> <p><input type="checkbox"/> 10g/m² (weight less than 5kg) <input type="checkbox"/> 15g/m² (weight of 5 to 10kg) <input type="checkbox"/> 20g/m² (weight greater than 10kg)</p>	<p>PRESCRIPTION</p> <p>Infuse PEDMARK _____ grams IV over <input type="checkbox"/> 15 minutes OR <input type="checkbox"/> _____ (30-60) minutes to be administered 6 hours after completion of cisplatin infusions that are 1 to 6 hours in duration. Dispense: Quantity sufficient of Pedmark (SDV) for each dose Refills: 12 months Cisplatin regimen: _____ (ex: 100mg/m² Q21D x2)</p>
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PEDMARK INFUSION ORDERS

PROVIDER SIGNATURE

Dispense as Written Signature _____ Date of Signature _____

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REQUIRED DOCUMENTATION

- | | |
|--|---|
| <p>CLINICAL DOCUMENTATION:</p> <p><input type="checkbox"/> RELEVANT CLINICAL NOTES OR TREATMENT PLAN
 <input type="checkbox"/> DOCUMENTATION OF CURRENT CHEMOTHERAPY REGIMEN AND NEED FOR PEDMARK
 <input type="checkbox"/> STATEMENT INDICATING PEDMARK IS NECESSARY TO REDUCE RISK OF CISPLATIN OTOTOXICITY
 <input type="checkbox"/> MOST RECENT LAB RESULTS
 <input type="checkbox"/> ENT/AUDIOLOGY NOTES AND RESULTS (if applicable)
 <input type="checkbox"/> CENTRAL VENOUS ACCESS PLACEMENT/VERIFICATION DOCUMENT</p> | <p>INTAKE DOCUMENTATION:</p> <p><input type="checkbox"/> PEDMARK ENROLLMENT FORM / INFUSION ORDER
 <input type="checkbox"/> COPY OF FRONT AND BACK OF INSURANCE CARD
 <input type="checkbox"/> PATIENT AUTHORIZATION FORM (if available)
 <input type="checkbox"/> FACE SHEET (Patient demographics, insurance details, contact information)</p> |
|--|---|

SITE OF CARE (if home infusion, proceed below)

- Home (12) Office (11) Independent Clinic (49) Inpatient (21)
 Off-Campus Outpatient Hospital (19) On-Campus Outpatient Hospital (22) Ambulatory Infusion Suite (24)

Complete This Section If Home Infusion
FENNEC HEARS ENROLLMENT FORM

ACCESS TYPE

(Also include Peripheral IV for Port Malfunction)

VENOUS ACCESS

- Peripheral IV
 - Peripheral IV may remain in place for multi-day home infusion therapy
 - Remove PIV at the end of the Pedmark infusion _____
provider initial
- Port _____ G _____ Inch Needle
 - De-access on last day of multi-day home infusion therapy
 - De-access after every Pedmark infusion
 - De-access per patient request
- PICC

VERIFICATION OF PLACEMENT (CENTRAL VENOUS ACCESS ONLY)

- Number of Lumens: 1 2 3
- Method of catheter placement verification: _____
(i.e. Radiological report/pst-insertion, chest x-ray, ECG verification for PICC, Ultrasound, Fluoroscopy)
 - Above central venous catheter successfully placed on _____ and viable for home infusion use
date of placement
 - Placement verified by _____
provider/clinician name and title
- If no documentation available, has the catheter previously been used for infusion without complication?*

_____ provider initial

FLUSH PROTOCOL

(If Heparin Flush is not selected OK to Saline lock port)

SALINE FLUSH

- 0.9% Saline Flush:** **Refills: 12 months**
Dispense: Quantity sufficient for each infusion
Flush catheter with 5-10mL for patency/SASH protocol

CATHETER FLUSH ORDERS

- Heparin Flush:** **Refills: 12 months**
Dispense: Quantity sufficient for each infusion
Flush catheter with 5mL of Heparin 100 units/mL per SASH protocol.

PEDMARK PRE-MEDICATION

For administration: 30 min. 60 min. prior to drug infusion at Home

- Ondansetron (Zofran) 8mg _____ IV
- Olanzapine (Zyprexa) *not shipped for home infusion _____ mg PO
- Metoclopramide (Reglan) 5-10mg _____ IV
- Lorazepam (Ativan) 0.5mg *not shipped for home infusion _____ PO
- Diphenhydramine (Benadryl) 25mg _____ IV PO
- Diphenhydramine (Benadryl) 12.5mg _____ IV PO
- Dexamethasone (Decadron) _____ IV PO
- LMX 4 or (EMLA) Lidocaine 2.5%/Prilocaine 2.5% cream - Apply topically 1 hour prior to starting IV or accessing port QTY: 1
- Famotidine (Pepcid) 20 mg _____ IV
- Prochlorperazine (Compazine) _____ 5mg IV 10mg IV

Dispense: Quantity Sufficient of SDV or tablet/capsule for each dose

Refills: 12 months

Other Pre-Medication(s): _____

SKILLED NURSING VISIT

Expected Cisplatin Infusion Start Time _____

Expected Cisplatin Infusion End Time _____

As needed for IV access, administration, and proper clinical monitoring. Administration procedures to be followed per pharmacy protocol.

- Post Infusion: Flush IV with 15 mL 0.9% Sodium Chloride Injection, USP at final rate of drug infusion.
- Vital Signs: At baseline and at every _____ minutes during infusion, at completion of post-infusion flush and 30 minutes after completion of post-infusion flush.
- Supplies: Provide infusion pump, IV Pole, back-up peripheral IV kit and all necessary infusion supplies, as necessary, if home health.

EMERGENCY MEDICATIONS

INSTRUCTIONS DURING REACTION

Dispense: 30 days Refills: 12 months

- 1) STOP PEDMARK
 - 2) START OR ADMINISTER EMERGENCY MEDICATIONS
 - Diphenhydramine 25 mg (>30 kg) or 1.25 mg/kg (≤30 kg) IV or IM; repeat x 1 in 15 min PRN
 - Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN
 - Corticosteroid - please specify (i.e. hydrocortisone, methylprednisolone): _____ Dose _____
 - 0.9% Sodium Chloride 500 mL (>30 kg) or 250 mL (<30 kg) IV at KVO rate PRN anaphylaxis: _____
 - 0.9% Saline _____ mL - administer at _____ mL/hr once PEDMARK infusion stops: _____
 - Other Emergency Medication(s): _____
 - 3) CALL PHYSICIAN
- RESUME PEDMARK INFUSION AT SAME STARTING RATE ONCE PATIENT STABLE

PEDMARK PRE-MEDICATION AND INFUSION REACTION MANAGEMENT ORDERS

Dispense as Written Signature _____

Date of Signature _____

Product Substitution Permitted Signature _____

Date of Signature _____

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