FENNEC HEARS
Hearing Education, Access & Reimbursement Support

Enrollment Form

HIPAA Authorization

FENNEC HEARS ENROLLMENT FORM

Please complete the form and email or fax with required documentation to:
email **pedmark@pro-spectus.com** or fax **(855) 612-5160**
Questions? Call: (855) 615-7946

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 #: _____

SITE OF CARE

☐ Home ☐ Office ☐ Independent Clinic ☐ Inpatient

☐ Off-Campus Outpatient Hospital ☐ On-Campus Outpatient Hospital ☐ Ambulatory Infusion

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

TREATMENT REGIMEN

Expected Cisplatin Start of Care Date _____

Cisplatin cut off time 2PM local time

Sample Dose Calculation: **Actual Patient Body Weight:** 24.9 kg **Body Surface Area (BSA):** 1.09 m^2 **PEDMARK Dose:** 20 g/m^2

Dose based on the patient's body weight; see chart below.

Calculation: Multiply the patient's BSA by the PEDMARK Dose: **1.09 m^2 x 20 g/m^2 = 21.8 g total PEDMARK to be administered.**

PEDMARK DOSE

Weight:____kg Height:____cm BSA:____m2

☐ 10g/m^2 (weight less than 5kg)

☐ 15g/m^2 (weight of 5 to 10kg)

☐ 20g/m^2 (weight greater than 10kg)

PRESCRIPTION

Infuse PEDMARK _____ grams IV over a minimum of _____ minutes (adjust based on pump limitation)

6 hours after completion of cisplatin infusions that are 1 to 6 hours in duration

Using a 25 or 50mL NS IV bag, flush IV tubing with NS 15mL after each infusion

Dispense: Quantity sufficient of PEDMARK (SDV) for each dose Refills: 12 months

Cisplatin regimen: _____ (ex: 100mg/m^2 Q21D x2)

PEDMARK INFUSION ORDERS

PROVIDER SIGNATURE

Cisplatin infusion should be scheduled and prioritized to ensure completion by 2 PM local time to support same-day PEDMARK in-home administration.

_____

Dispense as Written Signature Date of Signature

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REQUIRED DOCUMENTATION

CLINICAL DOCUMENTATION:

☐ RELEVANT CLINICAL NOTES OR TREATMENT PLAN

☐ DOCUMENTATION OF CURRENT CHEMOTHERAPY REGIMEN AND NEED FOR PEDMARK

☐ STATEMENT INDICATING PEDMARK IS NECESSARY TO REDUCE RISK OF CISPLATIN OTOTOXICITY

☐ MOST RECENT LAB RESULTS

☐ ENT/AUDIOLOGY NOTES AND RESULTS (if applicable)

☐ CENTRAL VENOUS ACCESS PLACEMENT/VERIFICATION DOCUMENT

INTAKE DOCUMENTATION:

☐ PEDMARK ENROLLMENT FORM / INFUSION ORDER

☐ COPY OF FRONT AND BACK OF INSURANCE CARD

☐ PATIENT AUTHORIZATION FORM (*if available*)

☐ FACE SHEET (*Patient demographics, insurance details, contact information*)

Continue to Page 2 if Home Infusion

FENNEC HEARS
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Patient Name: _____ Date of Birth: (MM/DD/YYYY)_____

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/post-insertion, chest x-ray, ECG verification for PICC, Ultrasound, Fluoroscopy)

☐ Above central venous catheter successfully placed on _____ *date of placement* and viable for home infusion use

☐ Placement verified by _____ *verified by (provider 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:**
Dispense: Quantity sufficient for each infusion

Refills: 12 months
Flush catheter with 5-10mL for patency/SASH protocol

CATHETER FLUSH ORDERS

☐ **Heparin Flush:**
Dispense: Quantity sufficient for each infusion

Refills: 12 months
Flush catheter with 5mL of Heparin 100 units/mL per SASH protocol.

PEDMARK PRE-MEDICATION

Dispense: Quantity Sufficient of SDV or Tablet/Capsule for Each Dose | Refills 12 Months

Prescribing physician will use their independent professional judgement for each individual patient's treatment recommendations

At-home Infusions	Check to Include	Pre-Medication	Provider Selected Dose (mg)	Admin Route (IV or PO)		Administrative Notes
Night Before PEDMARK:	☐	Olanzapine (Zyprexa) 5mg-10mg		☐ PO		Not shipped for home infusion
30-60 mins Before PEDMARK:	☐	Lorazepam (Ativan) 0.5mg-1.0mg		☐ PO		Not shipped for home infusion
	☐	Famotidine (Pepcid) 20mg		☐ PO	☐ IV	
	☐	LMX 4 or (EMLA) Lidocaine 2.5%/Prilocaine 2.5% cream				Apply topically 1 hour prior to starting IV or accessing port QTY: 1
	☐	Diphenhydramine (Benadryl) 12.5-25mg (please specify)		☐ PO	☐ IV	
	☐	Dexamethasone (Decadron) 2-20mg (please specify)		☐ PO	☐ IV	20 mg max daily dose
	☐	Ondansetron (Zofran) 8mg		IV		24 mg max daily dose
	☐	Metoclopramide (Reglan) 10mg		☐ PO	☐ IV	
	☐	Prochlorperazine (Compazine) 5-10mg (please specify)		IV		
Other Medication(s):	☐	List:		☐ PO	☐ IV	
	☐	List:		☐ PO	☐ IV	
	☐	List:		☐ PO	☐ IV	
	☐	List:		☐ PO	☐ IV	

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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