Provider Order Form

# IDELVION [Coagulation Factor IX (Recombinant), Albumin Fusion Protein]

## PATIENT

Full Name: ______________________ DOB: ______________

Mobile Phone: ______________________ Weight: ________ ☐ lbs ☐ kg

Allergies: ______________________ ☐ NKDA

**Patient status:** ☐ New to therapy ☐ Continuing therapy Last Treatment Date: ____________ Next Treatment Date: __________

## DIAGNOSIS ICD-10 code (must be specified)

☐ Congenital Factor IX Disorder D67 ☐ Other: ______________________

## PROVIDER

Provider Name: ______________________ Provider NPI: ______________________

Practice Name: ______________________ Referral Coordinator Name: ______________________

Practice Address: ______________________

Phone: ______________ Fax: ______________ Email: ______________________

## THERAPY ADMINISTRATION

| Medication | Dose | Frequency |
|---|---|---|
| ☐ Idelvion [Coagulation Factor IX (Recombinant), Albumin Fusion Protein], IV | ☐ Prophylaxis: 40-55 IU/kg body weight | ☐ Every 7 days (Patients <12 years of age) |
| | ☐ Prohylaxis: 25-40 IU/kg body weight | ☐ Every 7 days (Patients ≥12 years of age) |
| | ☐ Prophylaxis: 50-75 IU/kg body weight | ☐ Every 14 days (Patients ≥12 years of age) |
| | ☐ On Demand | ☐ Infuse ______ units (+/- 10%) slow IV push every ______ hours / days (circle one) for a total of ______ doses as needed for bleeding episodes. |

☐ Other: ______________________________________________

Refills ☐ Zero ☐ 12 months ☐ ______________. Order valid for 1 year unless otherwise stated. ____________________

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

## LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every ______________

☐ CMP ☐ at each dose ☐ every ______________

☐ CRP ☐ at each dose ☐ every ______________

☐ Other ______________ ☐ at each dose ☐ every ______________

## SPECIAL INSTRUCTIONS

## PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX

______________________________ ______________________

Provider Signature Date