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: ______
Phone Number: ______ Date of Birth: (MM/DD/YYYY) ______
E-Mail: ______ Gender: ☐ Male ☐ Female ☐ Unspecified
Preferred Method of Communication: ☐ Call ☐ Text ☐ Email
Venous Access: ☐ Peripheral IV ☐ Port ______ G ______ Inch Needle
Device: ☐ PIV for port access complications

INSURANCE INFORMATION

Primary Insurance Name: ______
Policy Number: ______
Group Number: ______
Insurance Phone Number: ______

Secondary Insurance Name: ______
Policy Number: ______
Group Number: ______
Insurance Phone Number: ______

Prescription Insurance: *(if different)* ______
Policy Number: ______ Rx Bin Number: ______
Group Number: ______ Rx PCN Number: ______
Insurance Phone Number: ______

Recommendation: Submitting a copy of the patient's insurance card(s) ensures accuracy and minimizes processing delays.

PRESCRIBER INFORMATION

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

SITE OF CARE

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

CATHETER ACCESS AND FLUSH PROTOCOL

ACCESS TYPE: ☐ Peripheral ☐ PORT *(Also include Peripheral IV for Port Malfunction)*

CATHETER FLUSH ORDERS

☐ **0.9% Saline Flush:**
Dispense: 30 Days
Refills: 12 months
Flush line/port with 10mL for patency/ SASH protocol

☐ **Heparin Flush:**
Dispense: 30 Days
Refills: 12 months
Flush port with ______ mL of Heparin ______ units/mL per SASH protocol.

☐ **CathFlo:**
2 mg/2 mL as directed.
Pharmacy authorized to dispense upon home health nurse validated port occlusion.
Dispense: 1 Kit **Refills: 12 months**

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 (*if available*)
☐ ENT/AUDIOLOGY NOTES AND RESULTS (*if available*)

INTAKE DOCUMENTATION:

☐ PEDMARK ENROLLMENT FORM / INFUSION ORDER
☐ FACE SHEET
(*Patient demographics, insurance details, contact information*)
☐ PATIENT AUTHORIZATION FORM (*if available*)

PEDMARK PRE-MEDICATION

For administration 30-60 min. prior to drug infusion at ☐ Home or ☐ in Facility

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

Dispense: 28 days Refills: 12 months

☐ Other Pre-Medication(s): ______

☐ Other Pre-Medication(s): ______

TREATMENT REGIMEN

PEDMARK DOSE

Weight:____kg Height:____cm BSA:____m2

- ☐ 10g/m2 (weight less than 5kg)
- ☐ 15g/m2 (weight of 5 to 10kg)
- ☐ 20g/m2 (weight greater than 10kg)

PRESCRIPTION

Infuse PEDMARK ______ grams IV over 15 minutes OR ______ minutes to be administered 6 hours after completion of cisplatin infusions that are 1 to 6 hours in duration.

______ vials/infusion Round up to the next whole vial (12.5g/100mL vial) **Dispense:** 28 days Refills: 12 months

______ PEDMARK infusions per month based on patient's cisplatin infusion regimen below:

Cisplatin regimen: ______

SKILLED NURSING VISIT

☐ 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.

PEDMARK INFUSION ORDERS

PROVIDER SIGNATURE

Product Substitution Permitted Signature ______ Date of Signature ______

Dispense as Written Signature ______ Date of Signature ______

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EMERGENCY MEDICATIONS

INSTRUCTIONS DURING REACTION

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: ______
- ☐ 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): ______
- ☐ Supplies: Provide infusion pump, IV Pole, back-up peripheral IV kit and all necessary infusion supplies, as necessary.

3) CALL PHYSICIAN ☐ 4) RESUME PEDMARK INFUSION AT SAME STARTING RATE ONCE PATIENT STABLE

EXAMPLES OF COMPLEX THERAPY INFUSION REACTIONS

- FEVER
- CHILLS/RIGORS
- HEADACHE
- RASH / ITCHING
- SWELLING/EDEMA
- NAUSEA/VOMITING
- ABDOMINAL PAIN
- IRRITABILITY
- HYPOTENSION
- DYSPNEA
- RESPIRATORY DISTRESS

PEDMARK INFUSION REACTION MANAGEMENT ORDERS

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