

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.

Most recent office visit note, Patient Demographic & Insurance Information, Medication List
Trough plasma ADA activity, trough dAXP levels, and/or total lymphocyte counts

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: D81.31 Severe combined immunodeficiency due to adenosine deaminase deficiency

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

REVCovi DOSAGE

Date of Last Treatment, If Continuation: _____

Patients transitioning from Adagen to REVCovi

Patient Weight: _____

The starting dose of REVCovi is 0.2 mg/kg weekly

Route: IM Dosage: _____

Adagen-naïve patients

The starting dose of REVCovi is 0.4 mg/kg weekly based on ideal body weight or actual body weight (whichever is greater), divided in two doses (0.2 mg/kg twice a week)

Route: IM Dosage: _____

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

Lab Orders:

Trough plasma ADA activity (pre-injection) every 2 weeks x 12 weeks every 4 weeks x 8 weeks

Trough plasma ADA activity (pre-injection) every 3 months

Other: _____

Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.