Gaucher's Disease - Enzyme Replacement Prescriber Order Form

To:	Phone:	Fax:	Date:
From:	Phone: X	Fax:	# Pages, Incl. Cover:

Patient Name:	Patient Phone:	DOB:
Address:	City: State:	Zip:

Primary Diagnosis

☐ E75.21 - Fabry (Anderson) Disease
☐ E75.22 - Gaucher Disease
☐ E75.249 - Niemann-Pick Disease, unspecified
☐ E77.0 - Defects in Post-Translational Modification of Lysosomal Enzymes
☐ E77.1 - Defects in Glycoprotein Degradation
☐ Other (ICD-10 Code and Description): _____

In order to service your patient and facilitate insurance authorization, please complete the sections below:

1

Ht: _____ ☐ in ☐ cm Wt: _____ ☐ lb ☐ kg Date: _____

☐ Attach Patient demographics, Insurance information, History and Physical, Medication list, and recent pertinent lab results

☐ Date of first dose: _____
☐ Number of doses administered: _____
Preferred site of administration:
☐ Patients Home ☐ Option Care Ambulatory Treatment Site

2 Prescription:

☐ Cerezyme (imiglucerase) ☐ VPRIV (velaglucerase alfa)

Dose: 60 units/kg or _____ units/kg IV every _____ week(s).
(Dose will be round up to the nearest vial size) ☐ Decline

Infusion Rate: Infuse in 100mls 0.9% NS over 60 minutes or _____minutes.
(Rate may be decreased in the event of an infusion related reaction.

Refills x _____

3 Supporting Orders:

☐ Acetaminophen 650 mgs orally 30 minutes before infusion.
☐ Diphenhydramine 25 mgs orally 30 minutes before infusion.
☐ Methylprednisolone 40 mgs IVP 20 minutes before infusion.
☐ Other: _____

- Anaphylaxis: Stop infusion, Call EMS, Give epinephrine 0.3 mgs IM, diphenhydramine 25 - 50 mg oral/injectable, 0.9% Sodium Chloride 250 mls per hour bag as needed per symptoms. Call prescriber.
- If applicable, flush intravenous access device per instructions in chart. →
- When appropriate: Provide infusion pump(s) and supplies necessary to administer therapy and skilled nurse to administer doses in the home/alternate care setting via vascular access device.
- Refill ancillary medications x 1 year.
  *Liquid dosage form in appropriate concentration/amount may be dispensed upon patient request.

Access Device Flush Protocol	0.9% Sodium Chloride Flush	Heparin
Peripheral	2 - 3 ml pre/post use	1 - 3 ml (10 units/ml) post use; maintenance q24hr
Peripheral-Midline	3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (100 units/ml) post use; maintenance q24hr
PICC & Central Tunneled & Non-tunneled	5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (heparin 100 units/ml) *or* 5 ml (10 units/ml) post use; maintenance q24hr
Implanted Port	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw	3 - 5 ml (100 units/ml) post use; maintenance if accessed 3 - 5 ml q24hr or if not accessed 3 - 5 ml weekly to monthly
Valved Catheters: Chest, PICC, Midline	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A

4 Lab and Other Orders:

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Physician Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Office Contact: _____

Local Contact Information: _____

Fax to: _____

