

Gaucher's Disease - Enzyme Replacement Prescriber Order Form

To:	Phone:	Fax:	Date:
From:	Phone: X	Fax:	# Pages, Incl. Cover:
Patient Name:		Patient Phone:	
Address:		City:	State: Zip:

Primary Diagnosis

<input type="checkbox"/> E75.21 - Fabry (Anderson) Disease <input type="checkbox"/> E75.22 - Gaucher Disease <input type="checkbox"/> E75.249 - Niemann-Pick Disease, unspecified	<input type="checkbox"/> E77.0 - Defects in Post-Translational Modification of Lysosomal Enzymes <input type="checkbox"/> E77.1 - Defects in Glycoprotein Degradation <input type="checkbox"/> Other (ICD-10 Code and Description): _____
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In order to service your patient and facilitate insurance authorization, please complete the sections below:

1	Ht: _____ <input type="checkbox"/> in <input type="checkbox"/> cm Wt: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Date: _____ <input type="checkbox"/> Attach Patient demographics, Insurance information, History and Physical, Medication list, and recent pertinent lab results	<input type="checkbox"/> Date of first dose: _____ <input type="checkbox"/> Number of doses administered: _____ Preferred site of administration: <input type="checkbox"/> Patients Home <input type="checkbox"/> Option Care Ambulatory Treatment Site
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2	Prescription: <input type="checkbox"/> Cerezyme (imiglucerase) <input type="checkbox"/> VPRIV (velaglucerase alfa) Dose: 60 units/kg or _____ units/kg IV every _____ week(s). (Dose will be round up to the nearest vial size) <input type="checkbox"/> 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 _____
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3 Supporting Orders: <input type="checkbox"/> Acetaminophen 650 mgs orally 30 minutes before infusion. <input type="checkbox"/> Diphenhydramine 25 mgs orally 30 minutes before infusion. <input type="checkbox"/> Methylprednisolone 40 mgs IVP 20 minutes before infusion. <input type="checkbox"/> Other: _____ <ul style="list-style-type: none"> 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:
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I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____	Date: _____
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Physician Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	Office Contact: _____
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Local Contact Information: _____

Fax to: _____