☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600
www.thrivewellinfusion.com

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

INFUSION ORDERS
CEREZYME (IMIGLUCERASE)

Date: _____

Mission Medical

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location*:

DIAGNOSIS AND ICD 10 CODE

☐ Type I Gaucher Disease ICD 10 Code: E75.22

REQUIRED DOCUMENTATION

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ Beta-glucosidase leukocyte (BGL) Enzyme Test Results
☐ Clinical/Progress notes
☐ Labs and Tests supporting primary diagnosis

Please indicate if your patient's disease has caused any of the following, *check all that apply:*

☐ Anemia ☐ Moderate to Severe Hepatosplenomegaly ☐ Skeletal Disease ☐ Thrombocytopenia (Plt ≤120,000)
☐ Symptomatic Disease (bone pain, fatigue, dyspnea, angina, abdominal distention, or diminished QOL)

MEDICATION ORDERS

Dosing	☐ Cerezyme 60 units/kg IV every 2 weeks**
	☐ Cerezyme _____ units/kg IV_____ **
	(Dosing ranges from 2.5 units/kg given 3 times per week to 60 units/kg given every 2 weeks)
Patient's Most Recent Weight = _____ kg	
Refills: ☐ X 6 months ☐ X 1 ye ar ☐ _____ doses (all doses including initial loading)	

** Patient weight is required for all weight-based orders.

PRESCRIBER INFORMATION

Prescriber Name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

ORDERING PROVIDER

Signature _____ _____

X Date

Provider _____ Phone _____ Fax _____