

INFUSION ORDERS CEREZYME (IMIGLUCERASE)

Date: _____

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

- | | |
|---|--|
| <input type="checkbox"/> This signed order form by the provider | <input type="checkbox"/> Clinical/Progress notes |
| <input type="checkbox"/> Patient demographics AND insurance information | <input type="checkbox"/> Labs and Tests supporting primary diagnosis |
| <input type="checkbox"/> Beta-glucosidase leukocyte (BGL) Enzyme Test Results | <input type="checkbox"/> Other_____ |

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 \leq 120,000)
 Symptomatic Disease (bone pain, fatigue, dyspnea, angina, abdominal distention, or diminished QOL)
 Other_____

MEDICATION ORDERS

Dosing	<input type="checkbox"/> Cerezyme 60 units/kg IV every 2 weeks** <input type="checkbox"/> 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:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 ye ar <input type="checkbox"/> _____ 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 _____