US infusions
11500 State Hwy 121 Ste 910, Frisco, TX 75035
P: 469-200-2605 F: 469-200-2606 usinfusions.org

CEREZYME (IMIGLUCERASE) INFUSION ORDERS

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

DIAGNOSIS AND ICD-10 CODE:

Diagnosis: ☐ Gaucher Disease
☐ Type 1 ☐ Type 3

ICD-10 Code: E75.22

Patient Weight: _____ lbs. (required) Allergies: _____

PRESCRIPTION:

Cerezyme: ☐ **Dose:** 60units/kg IV every 2 weeks x1 year
☐ **Other Dosage:** _____

Pre-Medication Orders: ☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO/IV
☐ Benadryl 25 mg PO
☐ Solumedrol ____ mg IV
☐ Other: _____

Prescriber to monitor for antibody formation during 1st year of treatment.

Lab Orders: _____ **Lab Frequency:** _____

Other orders: _____

PROVIDER INFORMATION:

By signing this form, you authorize US Infusions and its staff to handle prior authorizations, coordinate with insurance providers, and determine the patient's preferred site of care.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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COMPREHENSIVE SUPPORT FOR CEREZYME (IMIGLUCERASE) THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

REQUIRED ASSOCIATED DOCUMENTATION:

- ☐ Signed and completed order (MD/prescriber to complete page 1)
- ☐ Patient demographic information and insurance information
- ☐ Patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Does the patient have symptomatic Gaucher Disease as evidence by moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, and/or splenomegaly? ☐ Yes ☐ No
  - ☐ Does the patient have a history of failure or intolerance to VPRIV? ☐ Yes ☐ No
- ☐ Labs and/or test results to support diagnosis
  - ☐ CBC, Hepatic Function Tests
- ☐ Other medical necessity: _____

CLINICAL DOCUMENTATION REQUIRED

- ☐ **Glucocerebrosidase enzyme activity** (Must show low enzyme activity consistent with Gaucher disease)
- ☐ **GBA genetic testing** (GBA1 mutation analysis)

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606