☐ *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

Office: 212-803-3339 Fax : 646-768-8600

☐ *Manhattan* 225 E 70th Street Suite 1E New York, NY 10021
☐ *Queens* 64-05 Yellowstone Blvd CF104 Forest Hills, NY 11375
☐ *Manhattan* 225 East 70th Street New York, NY 10021
☐ *Holbrook/ Ronkonkoma* 233 Union Ave Suite 207 Holbrook, NY 11741
☐ *Scarsdale* 495 Central Park Avenue Suite 205 Scarsdale, NY 10583
☐ *5 Towns* 141 Washington Avenue Cedarhurst, NY 11559
☐ *Long Beach* 917 Beech Street Long Beach, NY 11561
☐ *Riverhead* 1228 E Main Street Suite A Riverhead, NY 11901

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	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Beta-glucosidase leukocyte (BGL) Enzyme Test Results	☐ 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 ≤120,000)	
☐ Symptomatic Disease (bone pain, fatigue, dyspnea, angina, abdominal distention, or diminished QOL) ☐ Other___________	

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 ____________