

Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830



Pegunigalsidase alfa-iwxj (Elfabrio) Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

LABORATORY ORDERS
<input type="checkbox"/> CBC <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> CMP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> CRP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> Other: _____

PRE-MEDICATION ORDERS
<input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> cetirizine (Zyrtec) 10mg PO
<input type="checkbox"/> loratadine (Claritin) 10mg PO
<input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV
<input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV
<input type="checkbox"/> hydrocortisone (Solu-Cortef) <input type="checkbox"/> 100mg IV
<input type="checkbox"/> Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION
<input checked="" type="checkbox"/> Pegunigalsidase alfa-iwxj (Elfabrio) in 0.9% sodium chloride <ul style="list-style-type: none">Dose: 1mg/kgFrequency: once every two weeksRoute: Intravenous
<input checked="" type="checkbox"/> Flush with 0.9% sodium chloride at infusion completion
<input checked="" type="checkbox"/> Administer with 0.2 micron in line filter
<input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed)
Total dosages _____
Refills _____

SPECIAL INSTRUCTIONS
<div style="border: 1px solid black; height: 100px;"></div>

NOTES/ADDITIONAL COMMENTS:
<div style="border: 1px solid black; height: 50px;"></div>

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____