Connecticut
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Greenwich, CT 06830

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

VIMIZIM® (elosulfase alfa) ORDER FORM

Date: _____

PATIENT INFORMATION

Name:	Phone:	DOB: SEX: M ☐ F ☐
☐NKDA Allergies:		Weight lbs/kg:

PHYSICIAN INFORMATION

Physician Name*:	Practice Name:	
Address:	Office Contact Name:	Office Contact #:
Phone: Fax:	Email (for updates):	

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

VIMIZIM®:

☐ VIMIZIM is indicated for patients with Mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome). E76.210

DOSAGE AND ADMINISTRATION:

Recommended Dose

Pre-treatment with antihistamines with or without antipyretics is recommended 30 to 60 minutes prior to the start of the infusion.

PRE-MEDICATION

☐ Tylenol PO 650mg ☐1000 MG ☐other _____

☐ Solumedrol 125mg IV ☐other _____

☐ Benadryl ☐25mg ☐50mg ☐other _____ ☐ IV ☐PO

☐ Benadryl 50 mg ☐or PO

☐ Medication _____ Dose _____Route _____

☐ _____ *(other)* ☐ _____ *(other)*

WARNINGS AND PRECAUTIONS

https://www.vimizim.com/wp-content/uploads/2018/02/Prescribing-Information.pdf

WARNING: RISK OF ANAPHYLAXI

Life-threatening anaphylactic reactions have occurred in some patients during VIMIZIM (elosulfase alfa) infusions.

Anaphylaxis, presenting as cough, erythema, throat tightness, urticaria, flushing, cyanosis, hypotension, rash, dyspnea, chest discomfort, and gastrointestinal symptoms (e.g., nausea, abdominal pain, retching, and vomiting) in conjunction with urticaria, have been reported to occur during VIMIZIM (elosulfase alfa) infusions, regardless of duration of the course of treatment.

Closely observe patients during and after VIMIZIM (elosulfase alfa) administration and be prepared to manage anaphylaxis. Inform patients of the signs and symptoms of anaphylaxis and have them seek immediate medical care should symptoms occur. Patients with acute respiratory illness may be at risk of serious acute exacerbation of their respiratory compromise due to hypersensitivity reactions, and require additional monitoring.

VIMIZIM ORDERS

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE

☐ 300mg IV

☐ Other_____

FREQUENCY

☐ 2 mg/kg Weekly

☐ X _____ X weeks

☐ _____ weeks

Other_____

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Recent Progres notes addressing **VIMIZIM** in note

_____ Recent labs to **include CBC, CMP**, and please send any other recent labs.

_____ Other

ORDERING PROVIDER

Signature **X** _____ Date _____ **NPI**_____

Provider _____ Phone _____ Fax _____