

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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 $\leq$ 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

Provider _____ Phone _____ Date _____ Fax _____