Fairfield
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Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
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Greenwich, CT 06830

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

Mission Medical

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 _____