Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Forest Hills
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Sheepshead Bay
2546 East 17th Street
Fl, 1
Brooklyn, NY 11235

Long Island City
36-36 33rd
Suite 311
Long Island City, NY 11106

Bronx
226 West 238th Street
Bronx, NY 10463

Massapequa
97 Grand Avenue
Massapequa, NY 11758

NYC

E 56th & Park Midtown
120 East 56 Street
Suite 300
New York, NY 10022

E 70th St Upper East Side
225 E 70th Street
Suite 1E
New York, NY 10021

FIDI
30 Broad Street
Suite 401
New York, NY 10004

Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Gramercy
7 Gramercy Park West
Lower Level
New York, NY, 10003

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

Mission Medical

Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Port Jefferson
12 Medical Drive
Suite B
Port Jefferson Station, NY 11776

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Southampton
625 Hampton Road
Southampton, NY 11968

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Holbrook
233 Union Avenue
Suite 207
Holbrook, NY 11741

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

New Hyde Park
1991 Marcus Ave
Suite 110
Lake Success, NY, 11042

Woodbury
7600 Jericho Tpke,
Lower Level, Suite C500
Woodbury NY 11797

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 _____