Palmetto Infusion Services
COMPLIANCE

Phone: 800-809-1265

MRN:_____
DOB_____

Standard Plan of Treatment for Cerezyme

(Re)Certification Period From_____to_____

Note: We may require MD office notes and may require a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name _____HT:____Weight: ____

Allergies_____

Primary Diagnosis: **ICD-10 E75.22** Gauchers Disease

ORDERS:

Obtain weight each visit. Vital Signs baseline, then every 30 minute until complete
Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy.
Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn Normal Saline Flush 3-10 ml before and after infusion, followed by Heparin 100 units/ml 1 – 5 ml per line type. Pump, tubing, and supplies needed to complete prescribed therapy.

If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Drug:

CEREZYME _____ units/kg in 0.9% Normal Saline, every 2 wks IV (MAX dose 6800 units)

May dose at ½ dose every 2 weeks during drug shortages.

Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures please)

Physicians Signature:_____/_____ Date:_____
(Dispense as written) (Substitution Permitted)

Print Physician Name:_____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:

866-872-8920

Revised 10-22-15