



Phone: 800-809-1265

MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

**Standard Plan of Treatment for Elaprase**

(Re)Certification Period From \_\_\_\_\_ to \_\_\_\_\_

**Note:** We 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 Name: \_\_\_\_\_ Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_ Height: \_\_\_\_\_

Diagnosis: **ICD-10 E76.1** Hunter Syndrome (Mucopolysaccharidosis Type II (MPS II))

Pre-medicate:  None or 30 minutes prior to infusion:

Acetaminophen 650mg PO and Diphenhydramine 50 mg PO

**Orders:**

Obtain weight each visit. Vital Signs: baseline and every 30 minutes for duration of infusion. 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:**

**Elaprase 0.5mg/kg IV (round up to full vial) in 100ml NS infuse over 1-3hrs (no longer than 8 hrs) weekly**

Infusion rates: 8ml/hr x 15 min, then increase by 8ml/hr increments every 15 minutes in order to administer the full volume within the prescribed time period.

Other: \_\_\_\_\_

Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures please)

Physician's Signature: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

(Dispense as written)

(Substitution permitted)

Print Physician Name: \_\_\_\_\_

**PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:**

**866-872-8920**