Phone: 800-809-1265

MRN:________________________
DOB: ________________________

Standard Plan of Treatment for VPRIV

(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 60 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:

VPRIV ____ mg in, every 2 wks IV over 1-2 hours

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

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