Palmetto INFUSION

MRN:_____
DOB: _____

Standard Plan of Treatment for VPRIV

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 plans.

Patient's Name _____ HT: _____ Weight: _____ Allergies: _____

Primary Diagnosis: Gaucher Disease ICD-10 E75.22

Premedication:

☐ 500 mg Acetaminophen PO 30 minutes prior to infusion

☐ Other: _____

Orders:

VPRIV: _____ units in 100 ml 0.9% Normal Saline IV over one (1) hour every two (2) weeks

Infuse using 0.2 micron filter

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

(No Stamped Signatures Please)

Physicians Signature: _____/ _____ Date: _____
(No Stamped Signatures Please) (Dispense as written) (Substitution Permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920