

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: \_\_\_\_\_



### Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.