

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Cerezyme® (imiglucerase) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
	See list
	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

E75.22 - Gauchers Disease
- Other:

REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		IF ORDER CHANGE:
5			Continue current order until insurance approved
6			

MEDICATION ORDERS:

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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*FDA labeling recommends pre-medication with antihistamines and/or corticosteroids for patients who experience infusion reactions.

IV	Diphenhydramine	25mg	50mg		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

DRUG/DOSE:

Cerezyme® (imiglucerase) IV _____ units/kg in NS

May administer a 1/2 dose during product shortages

FREQUENCY:

<input type="checkbox"/>	Every 2 weeks
<input type="checkbox"/>	Other: _____

Infuse over 1-2 hours for patients weighing 18kg or greater.

Infuse over 2 hours for patients weighing less than 18kg.

SPECIAL/LAB ORDERS:

<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.



PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

_____	_____
Dispense as written/Brand medically necessary	Substitution permitted



Checklist for referrals to AccuRX Infusion:

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**

Palmetto Infusion 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. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com