Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ 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 corticosteriods 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 admnister a 1/2 dose during product shortages

FREQUENCY:

◯ Every 2 weeks

◯ 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:

◯ _____

_____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion 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	