Palmetto INFUSION®

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

Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Elaprase® (idursulfase) 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)

☐ E76.1 - Hunter Syndrome (Mucopolysaccharidosis Type II (MPS II))

☐ _____- Other:_____

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	
6	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: We 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

IV	Diphenhydramine	◯ 25mg	◯ 50mg						
	Methylprednisolone	◯ 40mg	◯ 125mg	◯ Other:					
	Famotidine	◯ 20mg	◯ 40 mg						
	Other:	◯							

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

MEDICATION:

☑ Elaprase® (idursulfase) in 100ml NS given IV to infuse per step protocol over 1-3 hrs (no longer than 8 hrs)

Infusion protocol: 8ml/hr x 15 minutes, then increase by 8ml/hr increments every 15 minutes in order to administer the full volume within the prescribed time period.

SPECIAL/LAB ORDERS:

◯ _____

_____

DOSE:

◯ 0.5mg/kg

◯ Other:_____

FREQUENCY:

◯ Infuse once a week

◯ Other: _____

☑ 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	