Palmetto INFUSION®

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

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

Vpriv® (velaglucerase alfa) 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 - Gaucher 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	Clinical progress notes supporting primary diagnosis including labs/tests		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: We *may* require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diag nosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

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:

☑ Vpriv® in 100ml NS via IV over 1 hour

DOSE:

◯ 60 units/kg

◯ Other: _____

SPECIAL/LAB ORDERS:

◯ _____

_____

FREQUENCY:

◯ Every 2 weeks

◯ 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	