

Aldurazyme Plan of Treatment

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

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: |
| <input type="checkbox"/> See list | <input type="checkbox"/> NKDA |

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

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|----------|
| E76.01 - |
| - 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 | LAST INFUSION DATE: |
| 3 | Full medication list | REQUIRED WASHOUT | NEXT INFUSION DATE: |
| 4 | Tried and failed therapies | FROM PREVIOUS | IF ORDER CHANGE: |
| 5 | | THERAPY: | <input type="checkbox"/> Continue current order until insurance approved |
| 6 | | | |

MEDICATION ORDERS:

NOTE: May be ineligible to receive Laronidase if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*Per FDA labeling consider premedication with antihistamines with or without antipyretic prior to start of infusion

| | | | | | | | | | | |
|----|--------------------|------|-------|--------|------------|-----------------|-------|-------|-------|--------|
| 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: | | | | | |

MEDICATION:

Aldurazyme in 100 to 250ml NS to be given IV via step protocol over about 3 hours

DOSE (rounded up to the nearest whole vial):

0.58mg/kg

Other: _____

FREQUENCY:


Weekly

Other: _____

SPECIAL/LAB ORDERS:

Refills x 12 months unless noted otherwise here:

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

| | | |
|---|---|---|
| <input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure | 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 | DATE: |
|---|------------------------|-------|