Palmetto INFUSION®

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

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

Vimizim® (elosulfase 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)

☐	E76.210 - Mucopolysaccharidosis type IVA (MPS IVA; Morquio A Syndrome)
☐	_____ - 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	Diagnostic testing		☐ **Continue current order until insurance approved**
6			

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive treatment if they present with symptoms of acute febrile respiratory illness or suspected infection due to the higher risk of life-threatening complications from hypersensitivity reactions.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*Per FDA labeling premedication of antihistamines (with or without antipyretics) is suggested

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:

☑ Vimizim® (elosulfase alfa) 2mg/kg given IV

INFUSION/FREQUENCY:

☐ Patient weight < 25 kg: dilute in 100ml NS over minimum of 3.5 hours every week. Start infusion at a rate of 3ml/hr for the first 15 minutes. If tolerated, rate can increase in increments of 6ml/hr every 15 minutes for a maximum infusion rate of 36ml/hr.

☐ Patient body weight > 25 kg: dilute in 250ml NS over minimum of 4.5 hours every (1) week. Start infusion at a rate of 6ml/hr for the first 15 minutes. If tolerated, rate can increase in increments of 12ml/hr every 15 minutes for a maximum infusion rate of 72ml/hr.

☐ Other: _____

_____

_____

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

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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	