

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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:
<input type="checkbox"/> See list	<input type="checkbox"/> 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	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	Diagnostic testing	THERAPY:	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	Other:	PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg			Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					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



Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- Patient demographics - address, phone number, SS#, etc.**
- Insurance information - copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com