

Cerezyme® (imiglucerase) Standard Plan of Treatment

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

PATIENT DEMOGRAPHICS:

Patient Name: _____

Patient's Phone: _____ 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 - Gauchers 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	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5		THERAPY:	
6			

Continue current order until insurance approved

MEDICATION ORDERS:

NOTE: We may 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

*FDA labeling recommends pre-medication with antihistamines and/or corticosteroids for patients who experience infusion reactions.

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/DOSE:

Cerezyme® (imiglucerase) IV _____ units/kg in NS.
 After completion of infusion, flush line with 20mL NS.
 May administer a 1/2 dose during product shortages

FREQUENCY:

Every 2 weeks

Other: _____

SPECIAL/LAB ORDERS:

Infuse over 1-2 hours for patients weighing 18kg or greater.
 Infuse over 2 hours for patients weighing less than 18kg.

Refills x 12 months unless noted otherwise here:

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

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observations if indicated

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

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