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

Cerezyme® (imiglucerase) Standard Plan of Treatment

Rev 4.28.25

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:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	
6	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **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 corticosteriods for patients who experience infusion reactions.

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/DOSE:

☑ Cerezyme® (imiglucerase) IV _____ units/kg in NS.
After completion of infusion, flush line with 20mL NS.
May admnister 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:

- ☑ 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

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

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	

Palmetto INFUSION

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