Gaucher's Disease - Enzyme Replacement Prescriber Order Form

To:	Phone:	Fax:	Date:
From:	Phone: X	Fax:	# Pages, Incl. Cover:

Patient Name:	Patient Phone:	DOB:	Gender:
Address:	City:	State:	Zip:

Primary Diagnosis

- ☐ E75.21 - Fabry (Anderson) Disease
- ☐ E75.22 - Gaucher Disease
- ☐ E75.249 - Niemann-Pick Disease, unspecified
- ☐ E77.0 - Defects in Post-Translational Modification of Lysosomal Enzymes
- ☐ E77.1 - Defects in Glycoprotein Degradation
- ☐ Other (ICD-10 Code and Description): _____

In order to service your patient and facilitate insurance authorization, please complete the sections below:

1

Ht: _____ ☐ in ☐ cm Wt: _____ ☐ lb ☐ kg Date: _____

☐ Attach Patient demographics, Insurance information, History and Physical, Medication list, and recent pertinent lab results

☐ Date of first dose: _____

☐ Number of doses administered: _____

Preferred site of administration:

☐ Patients Home ☐ Option Care Ambulatory Treatment Site

2 Prescription:

☐ Cerezyme (imiglucerase) ☐ VPRIV (velaglucerase alfa)

Dose: 60 units/kg or _____ units/kg IV every _____ week(s). (Dose will be round up to the nearest vial size) ☐ Decline

Infusion Rate: Infuse in 100mls 0.9% NS over 60 minutes or _____ minutes. (Rate may be decreased in the event of an infusion related reaction)

Refills x _____

3 Supporting Orders:

- ☐ Acetaminophen 650 mgs orally 30 minutes before infusion.
- ☐ Diphenhydramine 25 mgs orally 30 minutes before infusion.
- ☐ Methylprednisolone 40 mgs IVP 20 minutes before infusion.
- ☐ Other: _____
- Anaphylaxis: Stop infusion, Call EMS, Give epinephrine 0.3 mgs IM, diphenhydramine 25 - 50 mg oral/injectable, 0.9% Sodium Chloride 250 mls per hour bag as needed per symptoms. Call prescriber.
- If applicable, flush intravenous access device per instructions in chart. →
- When appropriate: Provide infusion pump(s) and supplies necessary to administer therapy and skilled nurse to administer doses in the home/alternate care setting via vascular access device.
- Refill ancillary medications x 1 year.
  *Liquid dosage form in appropriate concentration/amount may be dispensed upon patient request.

Access Device Flush Protocol	0.9% Sodium Chloride Flush	Heparin
Peripheral	2 - 3 ml pre/post use	1 - 3 ml (10 units/ml) post use; maintenance q24hr
Peripheral-Midline	3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (100 units/ml) post use; maintenance q24hr
PICC & Central Tunneled & Non-tunneled	5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (heparin 100 units/ml) *or* 5 ml (10 units/ml) post use; maintenance q24hr
Implanted Port	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw	3 - 5 ml (100 units/ml) post use; maintenance if accessed 3 - 5 ml q24hr or if not accessed 3 - 5 ml weekly to monthly
Valved Catheters: Chest, PICC, Midline	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A

4 Lab and Other Orders:

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

Local Contact Information: _____

Fax to: **713-983-4647**

