

GENERAL ENZYME REPLACEMENT PRESCRIBER ORDER FORM			
Patient Name:		Date of Birth:	Gender:
Address:			
Phone:	Height: _____ ☐ inches ☐ cm	Weight: _____ ☐ lbs ☐ kg Date weight obtained: _____	
Clinical Information			
Primary Diagnosis Description:		ICD-10 Code:	
Allergies: ☐ NKDA OR (List):			
Enzyme Prescription			
Drug Name _____		Dose _____	Frequency _____
Infusion Rate _____		Refill as directed x 1 year	
Ancillary Orders			
Anaphylaxis Kit Dosage: ▪ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN ▪ Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max per dose) IV or IM; repeat x 1 in 15 min PRN no improvement. ▪ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.			
Medication Orders ☐ Acetaminophen 650 mg orally 30 minutes before infusion. ☐ Diphenhydramine 25 mg orally 30 minutes before infusion. ☐ Methylprednisolone sodium succinate 40 mg IVP 20 minutes before infusion. ☐ Other: _____			
IV Flush Orders • <u>Peripheral</u>: 0.9% Sodium Chloride 3 to 5 mL pre-/post-use. • <u>Implanted Port</u>: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed. If unable to obtain implanted port access, it is acceptable to establish a peripheral IV access and administer peripherally.			
Lab Orders ☐ No labs ordered at this time. ☐ Other: _____			
Skilled nurse to assess and administer via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year. 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>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i>			
Prescriber Signature: _____		Date: _____	
Prescriber Information			
Prescriber Name:		Phone:	Fax:
Address:		NPI:	
City, State:	Zip:	Office Contact:	
Fax completed form, insurance information, and clinical documentation to: 713-983-4647			
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