Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

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

Cerezyme® (imiglucerase) 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:	☐ 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	

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

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

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	