

**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_

**REFERRAL STATUS**

New Referral       Dose or Frequency Change       Order Renewal

Is this the first dose?  Yes  No, date of last infusion: \_\_\_\_\_ Line type:  PIV  PICC  Port  Other

**DIAGNOSIS AND ICD-10 CODE**

Type I Gaucher Disease      ICD-10 Code: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

**REQUIRED DOCUMENTATION**

This signed order form by the provider       H&P and Clinical/Progress notes supporting primary diagnosis  
 Patient demographics AND insurance information       Labs and Tests supporting primary diagnosis  
 Beta-glucosidase leukocyte (BGL) Enzyme Test Results

Please indicate if your patient's disease has caused any of the following, *check all that apply*:

Anemia     Moderate to Severe Hepatosplenomegaly     Skeletal Disease     Thrombocytopenia (Plt ≤ 120,000)  
 Symptomatic Disease (bone pain, fatigue, dyspnea, angina, abdominal distention, or diminished QOL)

**MEDICATION ORDERS**

Dosing  Cerezyme \_\_\_\_\_ units/kg IV every 2 weeks  
 Cerezyme \_\_\_\_\_ units/kg IV \_\_\_\_\_  
 (Dosing ranges from 2.5 units/kg given 3 times per week to 60 units/kg given every 2 weeks)

Refills\*:  X 6 months     X 1 Year     Other: \_\_\_\_\_  
 \*(if not indicated, order will expire 1 year from date signed)

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline  
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration  
 RN to flush and lock VAD/CVAD per company protocol:  
 Other: \_\_\_\_\_

**PREMEDICATION ORDERS**

Acetaminophen 650mg PO prior to infusion       Other: \_\_\_\_\_  
 Diphenhydramine 25mg PO prior to infusion       Other: \_\_\_\_\_

**EMERGENCY MEDICATIONS**

Administer the following medications as needed for infusion-related reactions per company protocol:

**Adults (weight >40kg):**

Diphenhydramine 25mg-50mg PO  
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins  
 Acetaminophen 325mg-650mg PO  
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated  
 Epinephrine 0.3mg IM/SQ, may repeat x1  
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive  
 Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

**Pediatrics (weight <40kg): (may adjust with weight changes)**

Diphenhydramine 25mg PO  
 Diphenhydramine 25mg slow IV push over 2-5 mins  
 Acetaminophen 325mg PO  
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated  
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1  
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ NPI Number: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_