

Elaprase® (idursulfase) Referral Form



Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status:

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per VIVO protocols.

ELAPRASE THERAPY ADMINISTRATION

0.5 mg/kg IV weekly

LABORATORY ORDERS

- CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
OTHER _____

REQUIRED DOCUMENTATION

PREMEDICATIONS

- acetaminophen (Tylenol) 500mg 650mg / 1000mg PO
 cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25mg 50mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____
Frequency: _____

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

Diagnosis confirmation with either DNA testing or enzyme assay

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print)

Provider Signature

Date

Fax Numbers

Colorado: 303-418-4679
Florida: 904-930-4211
Texas: 469-340-0044

Nevada: 702-489-5744
New Jersey: 609-955-3711
Ohio: 216-400-0674
Oklahoma: 918-770-4421

Massachusetts: 203-724-4838
Pennsylvania: 215-399-9244
New York: 203-724-4838
Connecticut: 203-724-4838

Have a Question? (720) 902-4111

Email Referrals To: referrals@vivoinfusion.com

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