VPRIV (velaglucerase alfa)

Order Form
Rev. 05/16/2023

Infusion ASSOCIATES
Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ◉ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height (cm):

ICD-10 Code(s) & Description *(required)*:

☑ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ◉ Yes *(please fax IA a copy)* ◉ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

☐ ***(required)*** **Genetic testing results were attached.**

Is the patient enrolled in the Genzyme Gaucher registry? ◉ Yes ◉ No

PRE-MEDICATION ORDERS

◉ Diphenhydramine ◉ PO or ◉ IV ☐ 25mg or ☐ 50mg **OR** ◉ Cetirizine 10 mg PO

◉ Acetaminophen PO _____ mg

LAB ORDERS

Collect: ☐ CMP ☐ CBC w/ diff ☐ CBC w/o diff ☐ CBC w/ man diff ☐ _____

Lab Frequency: ◉ Every 3 months ◉ Every 6 months ◉ _____

THERAPY ADMINISTRATION

VPRIV (velaglucerase alfa) IV

Dose: 60 units/kg

Frequency: Every 2 weeks

Date of last infusion if not at IA: _____ RX Expiration Date: _____

Additional Notes from Referring Office:

_____ _____ _____

Provider Name (Print) **Provider Signature** **Date**