Enzyme Replacement Therapy Referral Form

☐ New to therapy ☐ Therapy Continuation

Date Initiated: ________________ Date Needed: ________________

PATIENT INFORMATION

Full name ______________________________

Date of birth ________________ ☐ Male ☐ Female

Street address ______________________________

City ________________ State ________ Zip ________

Primary phone ________________ Secondary phone ________________

Patient's guardian ________________ HIPPA Consent ☐ Yes ☐ No

Insurance company ______________________________

Phone ______________________________

Insured's name ______________________________

Relationship to patient ______________________________

ID ________________ Group ________________

Does patient have secondary insurance? ☐ Yes ☐ No

PRESCRIBER INFORMATION

Prescriber's name ______________________________

State License ______________________________

NPI ________________ DEA # ________________

Address ______________________________

Phone ______________________________

Fax ______________________________

CLINICAL INFORMATION

Diagnosis code: ______________________________

Weight: ________ Height: ________ Date recorded: ________

☐ NKDA ☐ Known drug allergies ______________________________

Previous Enzyme Replacement therapies (if applicable):

____

Please provide copy of primary and secondary insurance with this form

PRESCRIBING INFORMATION

☐ Aldurazyme 2.9mg/5mL
☐ Cerezyme 400 unit
☐ Elaprase 6mg/3mL
☐ Fabrazyme 5mg and/or 35mg
☐ Kanuma 20mg/10mL
☐ Lumizyme 50mg
☐ Nexviazyme 100mg
☐ VPRIV 400 unit
☐ Xenpozyme 20mg
☐ **Other** ______________________________ (Specify Product)

Route: ☐ IV ☐ Other ______________________________

Dose: ________________ **Qty:** ________ **Refills:** ________ **Directions:** ______________________________

For home infusion patients only:

1. Pharmacy will calculate final infusion volume and rates suggested within manufacturer's package insert based on patient weight, unless otherwise specified.
2. Preferred final volume for administration (if applicable): ______________________________
3. Preferred infusion rates for administration (if applicable): ______________________________

☐ **Anaphylaxis Orders**

Epinephrine 1:1000:

- Adults/Pediatrics >30kg-Epinephrine 0.3mg pen-1 pack (2 pens): Inject 0.3mg IM into anterolateral thigh for severe allergic reaction. May repeat in 5-15 minutes if symptoms persist and call 911.
- Pediatrics 15kg-30kg-Epinephrine 0.15mg pen-1 pack (2 pens): Inject 0.15mg IM into anterolateral thigh for severe allergic reaction. May repeat in 5-15 minutes if symptoms persist and call 911.
- Pediatrics <15kg-Epinephrine 1 mg/mL ampule-1 ampule: Inject 0.01 mg/kg IM into anterolateral thigh for severe allergic reaction. May repeat in 5-15 minutes if symptoms persist and call 911.

Oral Diphenhydramine:

- Adults/Pediatrics ≥25kg-Diphenhydramine 25mg capsules-10 capsules: Give 25mg to 50mg PO as needed for mild to moderate infusion reaction. May repeat in 4 to 6 hours.
- Pediatrics <25kg- Diphenhydramine 12.5 tablets- 10 tablets: Give 12.5mg to 25mg PO as needed for mild to moderate infusion reaction. May repeat in 4 to 6 hours.

<u>for IV infusions ONLY</u>

IV/IM Diphenhydramine 50mg/mL vial:

- Adults/Pediatrics ≥25kg: Inject 25mg to 50mg IV or IM as needed for mild to severe allergic reaction. May repeat in 4 to 6 hours.
- Pediatrics <25kg: Inject 1-2mg/kg IV or IM for mild to severe allergic reaction. May repeat in 4 to 6 hours.

Sodium Chloride 0.9% Solution

- Adults/Pediatrics- 1000mL bag: Infuse IV at rate of 250mL/hr for severe allergic reaction.

IV access:

☐ Peripheral ☐ Port ☐ PICC

Flush Protocol:

Use 5mL to 10mL of 0.9% NaCl before and after each infusion. Sterile syringes required for PICC/PORT.

Maintain PICC with 3 to 5mL of 10unit/mL of heparin and maintain implanted port with 3 to 5mL of 100unit/mL of heparin.

Pre-medication:

☐ Acetaminophen 325mg tablets
Sig: Take two 325mg tablets (650mg) by mouth 30-60 minutes prior to infusion.
Qty: 2 per dose

☐ Diphenhydramine 25mg capsules
Sig: Take one to two 25mg capsules (25-50mg) by mouth 30-60 minutes prior to infusion.
Qty: 2 per dose

Medications to be used as needed:

☐ Lidocaine 2.5%/Prilocaine 2.5% Cream
Sig: Apply small amount to injection site 60 min prior to infusion
Qty: 1 tube

☐ Other Sig: ______________________________ Qty: ________

Pre/Post Hydration:

______ mL of ☐ 0.9% NaCl ☐ D5W ☐ before ☐ after ☐ concurrently at a rate of _______ mL/hour.

☐ Other: ______________________________

Home Infusion Nursing Care:

☐ If patient is naïve or established for less than six months on therapy: prescriber has reviewed patient history and risk for reaction and approves patient for administration in home setting.

☐ Infused in office or infusion center ☐ Home Nursing needed

☐ Nursing already coordinated:

Agency ________________ Phone: ________________

☐ RN to provide home nursing services for administration of ERT and as needed for IV site care and complications related to therapy. ***Patient must be six months reaction free prior to utilizing home infusion care.***

Supplies: Pharmacy will provide all supplies, ancillary equipment and fluids necessary for reconstitution, dilution and administration for home infusion.

Dispense (for all above): provide a 4-week supply or please specify if other: ______________________________

Refills (all above): 1-year supply OR ______________________________ (please specify)

Substitution Permissible. In order for a brand name product to be dispensed, the prescriber must handwrite "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" in the space provided: ______________________________

Prescriber's Signature (Dispense as Written) ______________________________ **Date:** ________________

Prescriber's Signature (Substitution Permissible) ______________________________ **Date:** ________________

For ARNP, NP, and PA, collaborative physician agreement is with: ______________________________

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.

©2023 All rights reserved. 062823