



# ELAPRASE (INDURSULFASE) Order Form

PHONE 515.225.2930 | FAX 515.559.2495

## Patient Information Demographics Attached

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION:** Please attach a copy of prescription/medical card(s) (front and back).

## Medical Information

Diagnosis: Hunter syndrome ICD-10 Code: \_\_\_\_\_  
Other: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
Patient Weight: \_\_\_\_\_ lbs.  
Allergies: \_\_\_\_\_  
Clinical/progress notes, labs and tests supporting primary diagnosis attached  
**Labs:** Required labs to be drawn by: Infusion Clinic Referring Physician  
**Lab Orders:** \_\_\_\_\_

## Elaprase Orders

**Elaprase** Dose: 0.5 mg/kg IV every week  
Other: \_\_\_\_\_ mg every \_\_\_\_\_  
**Premedications:** Tylenol 1000 mg PO and Benadryl 25 mg PO to be given 30 minutes before infusion (if not contraindicated)  
**\*\*Patient must bring own EpiPen to each infusion.\*\***  
**\*\*Once we receive all necessary documentation, we will schedule the patient's treatment.**  
**Additional Orders/Comments:**

## Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

**Physician Signature:** \_\_\_\_\_ **Physician Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Contact Person:** \_\_\_\_\_

## Service Areas

Des Moines, IA    West Des Moines, IA    Chicago, IL    Omaha, NE    Buffalo, NY    Dallas, TX  
Phoenix, AZ    Other: \_\_\_\_\_

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