Hy-Vee health INFUSION CARE

CEREZYME (IMIGLUCERASE) 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: Gaucher disease 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: ______________________________

Cerezyme Orders

Cerezyme Dose: 60 mg/kg IV every 2 weeks

Other dosage: ______________________________

Protocol: Tylenol 1000 mg PO

Benadryl 25 mg PO

Solumedrol ________ mg

Other: __________

Prescriber to monitor for antibody formation during 1st year of treatment.

****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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