

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.

Most Recent Office Visit Note, Insurance Info, Medication List, and documentation supporting diagnosis of Hunter Syndrome

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: E76.01 E76.1

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

The following medications will be administered per prescribing information:

No Premeds

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

ELAPRASE DOSAGE

Patient Weight in KG: _____

_____ **0.5 mg per kg of body weight administered once every week as an intravenous infusion**

Route: IV

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

Lab Orders: List: _____

Prior to first appointment Other Frequency: _____

Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.