

Date: \_\_\_\_\_ Treatment Location: \_\_\_\_\_

**PROVIDERS: Please include the following to expedite the order.**

Most recent office visit note, Patient Demographic & Insurance Information, Medication List

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Patient Contact Number: \_\_\_\_\_

DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs / kg Height: \_\_\_\_\_

Diagnosis:  E75.22 Type 1 Gaucher

Other Dx/ICD10: \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_

**Signature:** \_\_\_\_\_

NPI: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Contact Email: \_\_\_\_\_

## PREMEDS

No Premeds  Other:

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

## ELELYSO DOSAGE

Date of Last Treatment, If Continuation: \_\_\_\_\_

**Treatment-naive:** 60 units/kg administered every other week

**Switching from imiglucerase:** \*Patients previously treated on a stable dosage of imiglucerase are recommended to begin treatment with ELELYSO at the same dose. \_\_\_\_\_ units every other week

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.