PARAGON HEALTHCARE

CEREZYME (IMIGLUCERASE) INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Diagnosis: ☐ Gaucher Disease

☐ Type 1 ☐ Type 3

ICD-10 Code: E75.22

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Cerezyme: ☐ Dose: 60units/kg IV every 2 weeks x1 year

☐ Other Dosage: _____

Pre-Medication Orders: ☐ Tylenol 1000mg PO

☐ Benadryl 25 mg PO

☐ Solumedrol _____ mg IV

☐ Other: _____

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

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Paragon ☐ Referring Provider

Other orders: _____

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

PARAGON HEALTHCARE

COMPREHENSIVE SUPPORT FOR CEREZYME (IMIGLUCERASE) THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Does the patient have symptomatic Gaucher Disease as evidence by moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, and/or splenomegaly? ☐ Yes ☐ No
  - ☐ Does the patient have a history of failure or intolerance to VPRIV? ☐ Yes ☐ No
- ☐ Include labs and/or test results to support diagnosis
  - ☐ CBC, Hepatic Function Tests
- ☐ Other medical necessity: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance