A Carelon Company

VPRIV (VELAGLUCERASE ALFA) THERAPY INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:			Email:
Address:		City: State:	ZIP:
NPI #:	DEA#:		Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Adult Dosing	Refills
VRPIV (velaglucerase alfa)	☐ 60 units/kg IV every 2 weeks ☐ Other dose: ___________________________	☐ x 1 year ☐ ___________

Premedication orders:

- ☐ Acetaminophen ☐ 500mg ☐ 1000mg PO
- ☐ Solu-Medrol _______ mg IVP
- ☐ Loratadine 10mg PO
- ☐ Normal Saline 500mL IV
- ☐ Diphenhydramine 25mg PO
- ☐ Diphenhydramine 25mg IV
- ☐ Cetirizine 10mg PO
- ☐ Cetirizine 10mg IVP
- ☐ Other: _________________________

Other orders: ____

Lab Orders: ____ Lab frequency: ____________________

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

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

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.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR VPRIV (VELAGLUCERASE ALFA) THERAPY

PATIENT INFORMATION

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

☐ Include labs and/or test results to support diagnosis

☐ CBC, Hepatic Function Tests

☐ Other medical necessity: ______________________________