



**PARAGON**  
HEALTHCARE

A Carelon Company

# ENZYME THERAPY ORDER SET

**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: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> 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
<b>Cerezyme</b> (imiglucerase)	<input type="checkbox"/> 60 units/kg IV every 2 weeks <input type="checkbox"/> Other dose: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<b>Elbafrio</b> (pegunigalsidase alfa)	<input type="checkbox"/> 1 mg/kg IV every 2 weeks <input type="checkbox"/> Other dose: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<b>Elaprase</b> (indursulfase)	<input type="checkbox"/> 0.5 mg/kg IV every week <input type="checkbox"/> Other dose: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<b>Nexviazyme</b> (avalglucosidase alfa)	<input type="checkbox"/> 20 mg/kg IV every 2 weeks <input type="checkbox"/> Other dose: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<b>VRPIV</b> (velaglucerase alfa)	<input type="checkbox"/> 60 units/kg IV every 2 weeks <input type="checkbox"/> Other dose: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
<b>Xenpozyme*</b> (olipudase alfa)  <small>*Note: Adjusted body weight will be used for BMI &gt;30 unless otherwise indicated</small>	<input type="checkbox"/> New start, titrate as follows: <ul style="list-style-type: none"> <li>• Week 0 (0.1 mg/kg IV)</li> <li>• Week 2 &amp; 4 (0.3 mg/kg IV)</li> <li>• Week 6 &amp; 8 (0.6 mg/kg IV)</li> <li>• Week 10 (1 mg/kg IV)</li> <li>• Week 12 (2 mg/kg IV)</li> <li>• Week 14 and beyond (3 mg/kg IV every 2 weeks)</li> </ul> <input type="checkbox"/> 3mg/kg IV every 2 weeks <input type="checkbox"/> Other dose: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

### Premedication orders:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 1000mg PO | <input type="checkbox"/> Normal Saline 500mL IV  | <input type="checkbox"/> Cetirizine 10mg PO  |
| <input type="checkbox"/> Solu-Medrol _____ mg IVP  | <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Cetirizine 10mg IVP |
| <input type="checkbox"/> Loratadine 10mg PO  | <input type="checkbox"/> Diphenhydramine 25mg IV | <input type="checkbox"/> Other: _____        |

**Lab Orders:** \_\_\_\_\_ **Lab frequency:**  Each infusion  Other: \_\_\_\_\_

Required labs to be drawn by  Paragon Healthcare  Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwritten "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:**

PHI-REF-ORD-10484-V1

**PATIENT INFORMATION**

Name:

DOB:

**REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & 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

*Please answer the following based on patient's therapy:*

Cerezyme:

- Does the patient have a deficiency in glucocerebrosidase enzyme activity measured in white blood cells or skin fibroblasts?  Yes  No
- Does genotype testing indicate a mutation of two alleles of the glucocerebrosidase genome?  Yes  No
- Does the patient have any of the following:  
 anemia  bone disease  hepatomegaly  splenomegaly  thrombocytopenia

Elfabrio and Nexviazyme:

- Does enzyme assay demonstrate a deficiency of alpha-galactosidase enzyme activity or genetic testing?  Yes  No

Elaprase:

- Does enzyme assay demonstrate a deficiency of iduronate-2-sulfatase enzyme activity or genetic testing?  Yes  No

VPRIV:

- Does enzyme assay demonstrate a deficiency of beta-glucocerebrosidase (glucosidase) enzyme activity or genetic testing?  Yes  No

Xenpozyme:

- Does the patient have a deficiency of acid sphingomyelinase as measured in peripheral leukocytes, cultured fibroblasts, or lymphocytes?  Yes  No
- Does genetic testing indicate a pathogenic variant(s) in the sphingomyelin phosphodiesterase-1 (SMPD1) gene?  Yes  No

Include labs and/or test results to support diagnosis

Other medical necessity: \_\_\_\_\_