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: ☐ 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
Cerezyme (imiglucerase)	☐ 60 units/kg IV every 2 weeks ☐ Other dose: _____	☐ x 1 year ☐ _____
Elbafrio (pegunigalsidase alfa)	☐ 1 mg/kg IV every 2 weeks ☐ Other dose: _____	☐ x 1 year ☐ _____
Elaprase (indursulfase)	☐ 0.5 mg/kg IV every week ☐ Other dose: _____	☐ x 1 year ☐ _____
Nexviazyme (avalglucosidase alfa)	☐ 20 mg/kg IV every 2 weeks ☐ Other dose: _____	☐ x 1 year ☐ _____
VRPIV (velaglucerase alfa)	☐ 60 units/kg IV every 2 weeks ☐ Other dose: _____	☐ x 1 year ☐ _____
Xenpozyme* (olipudase alfa) *Note: Adjusted body weight will be used for BMI >30 unless otherwise indicated	☐ New start, titrate as follows: • Week 0 (0.1 mg/kg IV) • Week 2 & 4 (0.3 mg/kg IV) • Week 6 & 8 (0.6 mg/kg IV) • Week 10 (1 mg/kg IV) • Week 12 (2 mg/kg IV) • Week 14 and beyond (3 mg/kg IV every 2 weeks) ☐ 3mg/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: _____

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 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 ENZYME 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

Please answer the following based on patient's therapy:

Cerezyme:

- Does the patient have a deficiency in glucocerebrosidase enzyme activity meased in white blood cells or skin fibroblasts? ☐ Yes ☐ No
- Does genotype testing indicate a mutation of two alleles of the glucpcerebrosidase 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, cultered 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: _____