Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

Cerezyme (Imiglucerase)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO 30 minutes prior to infusion
☐ cetirizine (Zyrtec) 10mg PO 30 minutes prior to infusion
☐ loratadine (Claritin) 10mg PO 30 minutes prior to infusion
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV priorto infusion
☐ methylprednisolone (Solu-Medrol) ☐ 40mg | ☐ 125mg IV 30 minutes prior to infusion
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV 30 minutes prior to infusion
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Imiglucerase** (Cerezyme) in 0.9% sodium chloride, intravenous infusion, administer with 0.2 micron filter
- Dose: 60U/kg / ☐ Other: _____
- Frequency: ☐ every 2 weeks / ☐ Other: _____
- Administer over 1-2 hours. Dilute final amount of Cerezyme in 0.9% Sodium Chloride to a final volume of 100-200ml.

☐ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK