Imiglucerase (Cerezyme)

Provider Order Form *rev. 10/12/2022*

IVX HEALTH

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

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

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

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 prior to 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: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

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

FAX NUMBERS

☐ BAY AREA: 844-889-0275
☐ CHARLOTTE: 336-663-0143
☐ CINCINNATI: 844-946-0868
☐ CONNECTICUT: 860-955-1532
☐ CHICAGO: 312-253-7244
☐ COLUMBUS: 844-627-2675
☐ DAYTONA: 386-259-6096
☐ FT. LAUDERDALE: 754-946-2052
☐ HARRISBURG: 844-859-4235
☐ INDIANAPOLIS: 844-983-2028
☐ JACKSONVILLE: 904-212-2338
☐ KANSAS CITY: 844-900-1292
☐ ORLANDO: 844-946-0867
☐ PALM BEACH: 561-768-9044
☐ PHILADELPHIA: 844-820-9641
☐ RALEIGH: 919-287-2551
☐ SARASOTA: 941-870-6550
☐ SOUTHWEST FL: 813-283-9144
☐ TAMPA: 844-946-0849
☐ WEST TN/AR: 888-615-1445
☐ MIDDLE TN: 888-615-1445
☐ EAST TN: 615-425-7427