



Enzyme Replacement Therapy Order Form

Select patient referral location: Akron Blue Ash Cleveland Columbus Crestview Hills Springfield West Cincinnati
 Other _____

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

| | |
|---|--|
| Name: | DOB: |
| Home phone: | Other phone: |
| Email: | |
| Social Security #: | Allergies: |
| Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg |
| Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable): | |

2. PHYSICIAN INFORMATION

| | |
|------------------------------|-------------------------|
| Physician's name: | NPI#: |
| License #: _____ TIN#: _____ | DEA#: |
| Address: | |
| City: | State: _____ Zip: _____ |
| Office contact: | Email: |
| Office phone: | Office fax: |

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Type 1 Gaucher Disease Fabry Disease Pompe Disease ICD 10 (_____) Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

ENZYME REPLACEMENT THERAPY

Cerezyme
 Administer 60U/kg IV q 2 weeks IV OR
 Administer _____

Lumizyme
 Administer 20 mg/kg IV q 2 weeks IV OR
 Administer _____

Fabrazyme
 Administer 1 mg/kg IV q 2 weeks IV OR
 Administer _____

PRE-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg PO
 Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
 Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
 Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
 Prednisone _____ mg PO
 Other: _____

POST-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg PO
 Prednisone _____ mg PO
 Other: _____

6. LABS

| | | |
|--|--|---|
| <input type="checkbox"/> CBC w/Diff | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CRP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> CMP | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> ESR | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Hepatic Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Renal Panel | <input type="checkbox"/> each infusion | <input type="checkbox"/> Other frequency (specify): _____ |
| <input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____ | | |
| <input type="checkbox"/> Other (specify): _____ | | |

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE