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: ☐ M ☐ F	Weight: ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ 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 ______________________________

☐ Vital signs per HI Protocol

☐ Anaphylaxis & Hydration Management per HI Protocol

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

☐ CBC w/Diff ☐ each infusion ☐ Other frequency *(specify)*: __________

☐ CRP ☐ each infusion ☐ Other frequency *(specify)*: __________

☐ CMP ☐ each infusion ☐ Other frequency *(specify)*: __________

☐ ESR ☐ each infusion ☐ Other frequency *(specify)*: __________

☐ Hepatic Panel ☐ each infusion ☐ Other frequency *(specify)*: __________

☐ Renal Panel ☐ each infusion ☐ Other frequency *(specify)*: __________

☐ Quantiferon TB Gold, annually, last completed *(date)*: ____________________

☐ Other *(specify)*: ______________________________

7. SIGNATURE *(required)*

______________________________ ______________________________

PHYSICIAN'S SIGNATURE DATE