Enzyme Replacement Therapy Order Form

Select patient referral location: Akron Athens Blue Ash Cleveland Columbus Crestview Hills

Dayton Mansfield Perrysburg Springfield Toledo West Cincinnati

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 ______________