Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Type I Gaucher Disease ICD 10 Code: E75.22

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
*Patient may be required to submit a pregnancy test prior to treatment
☐ Clinical/Progress notes (must be within 1 year)
☐ Labs and Tests supporting primary diagnosis
☐ Beta-glucosidase leukocyte (BGL) Enzyme Test Results

Please indicate if your patient's disease has caused any of the following, check all that apply:

☐ Anemia ☐ Moderate to Severe Hepatosplenomegaly ☐ Skeletal Disease ☐ Thrombocytopenia (Plt ≤ 120,000)
☐ Symptomatic Disease (bone pain, fatigue, dyspnea, angina, abdominal distention, or diminished QOL)

MEDICATION ORDERS

**Patient weight required for weight-based orders.

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Dosing

☐ J1786 Cerezyme 60 units/kg IV every 2 weeks**
☐ J1786 Cerezyme _____ units/kg IV _____**
(Dosing ranges from 2.5 units/kg given 3 times per week to 60 units/kg given every 2 weeks)

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses (all doses including initial loading)**

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204 Mattoon, IL 61938
Ph. 217-258-4150 Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201 Effingham, IL 62401
Ph. 217-342-7500 Fax 217-342-7499

INFUSION ORDERS - CEREZYME (IMIGLUCERASE)

Clinics Scan to: Physician Orders