General Enzyme Replacement Prescriber Order Form

To:	Phone:	Fax:	Date:
From:	Phone: X	Fax:	# Pages, Incl. Cover:

Patient Name:	Patient Phone:	DOB:
Address:	City:	State: / Zip:

Primary Diagnosis

ICD-10 Code and Description: _____

In order to service your patient and facilitate insurance authorization, please complete the sections below:

1

Ht: _____ ☐ in ☐ cm Wt: _____ ☐ lb ☐ kg Date: _____

☐ Attach Patient demographics, Insurance information, History and Physical, Medication list, and recent pertinent lab results

☐ Date of first dose: _____

☐ Number of doses administered: _____

Preferred site of administration:

☐ Patients Home ☐ Option Care Ambulatory Treatment Site

2 Prescription:

Medication: _____ Dose: _____

Frequency: _____

Refills x _____

3 Ancillary Orders:

☐ Acetaminophen 650 mg orally 30 minutes before infusion

☐ Diphenhydramine 25 mg orally 30 minutes before infusion.

☐ Methylprednisolone Na Succ 40 mg IVP 20 minutes before infusion.

☐ Other: _____

- Anaphylaxis: Stop infusion, Call EMS, Give epinephrine 0.3 mgs IM, diphenhydramine 25 - 50 mg oral/injectable, 0.9% Sodium Chloride 250 mls per hour bag as needed per symptoms. Call MD.
- If applicable, flush intravenous access device per instructions in chart. →
- When appropriate: Provide infusion pump(s) and supplies necessary to administer therapy and skilled nurse to administer doses in the home/alternate care setting via vascular access device.
- Refill ancillary medications x 1 year.
  *Liquid dosage form in appropriate concentration/amount may be dispensed upon patient request.

Access Device Flush Protocol	0.9% Sodium Chloride Flush	Heparin
Peripheral	2 - 3 ml pre/post use	1 - 3 ml (10 units/ml) post use; maintenance q24hr
Peripheral-Midline	3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (100 units/ml) post use; maintenance q24hr
PICC & Central Tunneled & Non-tunneled	5 ml pre/post use; 5 ml pre/10 ml post lab draw	3 ml (heparin 100 units/ml) *or* 5 ml (10 units/ml) post use; maintenance q24hr
Implanted Port	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw	3 - 5 ml (100 units/ml) post use; maintenance if accessed 3 - 5 ml q24hr or if not accessed 3-5ml weekly to monthly
Valved Catheters: Chest, PICC, Midline	5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A

4 Lab and Other Orders:

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

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Local Contact Information: _____

Fax to: _____

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