Enzyme Replacement Therapy Order Form

Specialty360 ERT Team - Phone: 877-865-9035 Fax: 866-889-1667

☐ **NEW TO THERAPY** ☐ **THERAPY CONTINUATION** (on therapy since: _____)

DELIVER TO: ☐ **Patient's home** ☐ **Prescriber's office** ☐ **Infusion site** **Date Needed:**_____

PATIENT INFORMATION

Name: _____ ☐ M ☐ F Daytime Phone: _____

DOB: _____ Weight: _____ kg/lbs / Height: _____ in/cm _ Evening Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Allergies: _____ Other Medical History: _____

INSURANCE INFORMATION (Please include copy of front and back of insurance card if possible)

Provider/Plan: _____ **Secondary Insurance:** _____

Patient's ID# _____ Patient's ID# _____

Policyholder's Name (if not patient) _____ Policyholder's Name (if not patient) _____

Policyholder's DOB (if not patient) _____ Policyholder's DOB (if not patient) _____

Phone: _____ Phone: _____

Patient's Group# _____ SSN: _____ Patient's Group# _____ SSN: _____

DIAGNOSIS AND CLINICAL CRITERIA **REQUIRED**

Diagnosis Code: _____

IV Access: ☐ Peripheral ☐ Port ☐ PICC

Flush Protocol: ☐ 5cc 0.9% NaCl before and after infusion (peripheral) ☐ 10cc 0.9% NaCl before and after infusion (PICC/port) ☐ Other: _____
Maintain line with: ☐1cc 10U/cc heparin (peripheral) ☐ 5cc 10U/cc heparin (PICC) ☐5cc 100U/cc heparin (port)

Anaphylaxis kit: ☐ Provide anaphylaxis kit per protocol (epinephrine 1 mg/mL ampule, diphenhydramine 50 mg/mL vial, 1000cc 0.9% NaCl, all infusion supplies)
☐ Epinephrine Pen 2-pack (0.3 mg for ≥30 kg; 0.15 mg for <30 kg) Sig: Inject IM in event of anaphylaxis Qty: 1 pack Refills: PRN

Pre-medication: ☐ Acetaminophen ____ mg Route: _____ Sig: _____ Qty: _____ Refills: _____
☐ Diphenhydramine ____ mg Route: _____ Sig: _____ Qty: _____ Refills: _____
☐ EMLA cream Sig: _____ Qty: _____ Refills: _____
☐ Other _____ Sig: _____ Qty: _____ Refills: _____

Nursing Care: ☐ Home nursing needed ☐ Nursing already coordinated -- Agency: _____ Phone: _____ ☐ Infused in office

Infusion Site: (if other than office) Name: _____ Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Contact person: _____

Supplies: **AllianceRx Walgreens Prime to provide all supplies, fluids, and ancillary equipment necessary for home infusion**

Last infusion date: ____/____/____ **Next infusion date**: ____/____/____

PRESCRIPTION INFORMATION *** TO BE INFUSED AT MANUFACTURER RECOMMENDED RATE UNLESS OTHERWISE INDICATED***

Medication	Route	Strength	Dose	Qty	Directions/Frequency	Refills
Aldurazyme	IV	2.9 mg/5 mL				
Cerezyme	IV	400 unit				
Elaprase	IV	6 mg/3 mL				
Fabrazyme	IV	☐ 5 mg ☐ 35 mg				
Lumizyme **Office infusion ONLY**	IV	50 mg				
Vimizim	IV	5 mg/5 mL				
VPRIV	IV	400 unit				
Other: _____						

Practice Name: _____ Prescriber's Name: _____

Contact Name: _____ State License# _____ DEA# _____

Address: _____ NPI# _____ UPIN _____

City: _____ State: _____ ZIP Code: _____ Phone w/ Area Code: _____ Fax w/ Area Code: _____

Substitution Permissible. In order for a brand name product to be dispensed, the prescriber must handwrite "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" in the space provided: _____

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature (Required): _____ **Date:** _____

Please fax completed form to: 866-889-1667

****Please Attach: Recent clinical assessment or H&P, labs AND current medication list****