Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Cerezyme Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Gaucher Disease ICD-10 Code: E75.22
- ☐ Other_____ICD-10:_____

ORDER FOR CEREZYME (IMIGLUCERASE):

- ☐ **60units/kg IV every 2 weeks x 1 year**
- ☐ **Other Dosing: _____ x 1 year**

PRE-MEDICATIONS:

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☑ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478
**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised 04/25

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed Provider Orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

- ☐ Does the patient have symptomatic Gaucher Disease as evidence by moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, and/or splenomegaly?
  - ☐ Yes OR ☐ No
- ☐ Does the patient have a history of failure or intolerance to VPRIV?
  - ☐ Yes OR ☐ No

☐ Include labs and/or test results to support diagnosis

- ☐ CBC and Hepatic Function Tests - (please include results)

☐ Other medical necessity documentation (please include): _____

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