Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

ELAPRASE (IDURSULFASE)
INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes** supporting primary diagnosis

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Hunter Syndrome (ICD-10: _____)

J Code: J1743

ELAPRASE ORDERS

Pt. Weight _____ kg

☐ 0.5 mg/kg IV every week

Premedications: ☐ Tylenol 1000 mg PO ☐ Benadryl 25 mg PO to be given 30 minutes before infusion (if not contraindicated).

****Patient must bring own EpiPen to each infusion.**

****Once we receive all necessary documentation, we will schedule the patient's treatment.**

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	